

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

7858

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>  |  |   |  | c. LENGTH OF STAY IN 1b <i>1 day</i>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 5122 Craig Ave  |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Eva Kelly Adams</i>  |  |   |  | 4. DATE OF DEATH Month Day Year <i>August 4 1956</i>   |  |  |  |
| 5. SEX <i>F</i>   |  | 6. COLOR OR RACE <i>W</i>                   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>Nov 3, 1883</i>  |  |
| 9. AGE (In years last birthday) <i>72</i> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.      |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>                                 |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME <i>Albert Gumpman</i>     |  | 14. MOTHER'S MAIDEN NAME <i>Susan FARRITELL Itzel</i>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>  |  | 16. SOCIAL SECURITY NO. <i>578-03-43403</i> |  | 17. INFORMANT <i>John Adams</i>  |  | Address <i>5122 Craig Ave</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i><br>422.2 DUE TO <i>Chronic Myocarditis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Myocarditis</i><br>DUE TO (c) <i></i> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <i>1</i>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <i>8/4</i> , 19 <i>56</i> , to <i>8/4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7/14</i> , 19 <i>56</i> , and that death occurred at <i>3:30</i> AM, from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <i>E. J. Lusk</i> (M.D.)   |  |   |  | ADDRESS (Street, city or town, state) <i>East Port Md.</i>   |  |  |  |
| DATE SIGNED <i>7/4/56</i>   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 22b. DATE THEREOF <i>8/7/56</i>             |  | 22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>   |  | 22d. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Luskner &amp; Sons - Baets. 17 Md.</i>   |  |   |  | 24a. REG'D BY REGISTRAR <i>Aug 7, 1956</i>   |  | 24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| DEPARTMENT OF HEALTH<br>BALTIMORE, MARYLAND |  | DATE OF DEATH<br>1956 AUG 8            |  |
| NAME OF DECEASED<br>[Faint text]            |  | SEX<br>[Faint text]                    |  |
| AGE<br>[Faint text]                         |  | RACE<br>[Faint text]                   |  |
| PLACE OF BIRTH<br>[Faint text]              |  | PLACE OF DEATH<br>[Faint text]         |  |
| OCCUPATION<br>[Faint text]                  |  | CAUSE OF DEATH<br>[Faint text]         |  |
| MANNER OF DEATH<br>[Faint text]             |  | MEDICAL HISTORY<br>[Faint text]        |  |
| SIGNATURE OF PHYSICIAN<br>[Faint text]      |  | SIGNATURE OF REGISTRAR<br>[Faint text] |  |
| DATE OF SIGNATURE<br>[Faint text]           |  | TIME OF SIGNATURE<br>[Faint text]      |  |

RECEIVED  
 AUG 8 1956  
 BUREAU K. B.

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy of the same is to be furnished to the local health officer of the place where the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7883

## CERTIFICATE OF DEATH

07830

Reg. Dist. No. 24

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>AA Co</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>AA Co</u>                          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ferndale</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>40 yrs</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>John</u> First <u>Francis</u> Middle <u>Amiech</u> Last   |  |   |  | 4. DATE OF DEATH<br><u>Aug</u> Month <u>28</u> Day <u>1956</u> Year   |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Aug 18-1889</u>                                      |  |
| 9. AGE (In years, last birthday)<br><u>67</u> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Watchman</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                  |  |
| 13. FATHER'S NAME<br><u>Ferdinand Amiech</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Augusta Plinson</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br><u>John Amiech Jr</u> Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Bladder - (metastatic)</u><br><u>181X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage from bowel</u> DUE TO<br>(c) _____ |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. _____ p. m. _____<br>Month, Day, Year _____ 19 _____  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
|   |  |   |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |   |  |
| 21. I certify that I attended the deceased from <u>Feb -</u> 19 <u>56</u> to <u>Aug 28</u> 19 <u>56</u> that I last saw the deceased alive on <u>Aug 28</u> 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u>   |  |   |  | ADDRESS (Street, city or town, state) <u>Md</u> DATE SIGNED <u>8/28/56</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) _____   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>Aug 31-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Burne</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Glen Burne AA Co Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Bernard A Frank</u>  |  |   |  | ADDRESS<br><u>Glen Burne Md</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>Aug 30-56</u>                            |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>L. J. DeAlba</u>   |  |   |  |

\_\_\_\_\_

BUREAU V. 31

1956 31 106

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7884

# CERTIFICATE OF DEATH

07831 21  
Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Maryland</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waterbury</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Addie</u> Middle <u>Pauline</u> Last <u>Aulton</u>  |  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>31<sup>st</sup></u> Year <u>1956</u>   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>Col.</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-18-1927</u>                                  |
| 9. AGE (In years last birthday) <u>28</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>  | 11. BIRTHPLACE (State or foreign country) <u>Waterbury, Md</u>     |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |  | 13. FATHER'S NAME <u>Richard Aulton</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>Cathrine Hall</u>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, per. or unknown) <u>No</u> (If yes, give war or dates of service)                                     |  |
| 16. SOCIAL SECURITY NO. <u>—</u>  |  | 17. INFORMANT <u>Cathrine Aulton, Waterbury, Md</u> Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Broncho Pneumonia</u><br>491X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) DUE TO |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that I attended the deceased from <u>8/27/56</u> , 1956, to <u>8/31/56</u> , 1956, that I last saw the deceased alive on <u>8/31/56</u> , 1956, and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>110-Clay St. Annapolis, Md</u> DATE SIGNED <u>9/1/56</u>  |  |
| PHYSICIAN'S NAME (Type) <u>R. L. Richardson, M.D.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>9-2-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>  | 22d. LOCATION (City, town, or county) (State) <u>Waterbury, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md</u> ADDRESS   |  | 24a. REC'D BY REGISTRAR <u>1559</u> DATE   | 24b. REGISTRAR'S SIGNATURE <u>Thm J. French</u>                    |

# CERTIFICATE OF DEATH

18831

1956

BUREAU V. 3

SEP 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7885

## CERTIFICATE OF DEATH

07832 28

Name: Film G-201 8-9-56.

Reg. Dist. No.

|   |  |                                  |  |  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|----------------------------------|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b>   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Montgomery</b>   |  |  |  |   |  |  |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |                                  |  | c. LENGTH OF STAY IN b.<br><b>10yrs. 6mo. 14days</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington, Maryland</b> |  |  |  |   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |                                  |  | d. STREET ADDRESS  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lucinda</b>  |  |                                  |  | Middle<br><b>(Bonds)</b>   |  |  |  | Lost<br><b>Barnes</b>   |  |  |  | 4. DATE OF DEATH<br>Month<br><b>8</b><br>Day<br><b>8</b><br>Year<br><b>19 56</b>                    |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>JUNE 12-1866</b>                                |  | 9. AGE (In years last birthday)<br><b>90?</b> yrs.  |  | IF UNDER 1 YEAR<br>Months<br><b>0</b><br>Days<br><b>0</b><br>Hours<br><b>0</b><br>Min.<br><b>0</b> |  | IF UNDER 24 HRS.<br>Months<br><b>0</b><br>Days<br><b>0</b><br>Hours<br><b>0</b><br>Min.<br><b>0</b> |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unascertained</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Mississippi</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>Henry Levi</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lavina Levi</b>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>-----                                  |  |  |  | 16. SOCIAL SECURITY NO.<br>-----  |  |  |  |
| 17. INFORMANT<br><b>Hospital Records</b>  |  |                                  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br><b>450.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Senile Arteriosclerosis</b><br>DUE TO<br>(c) ----- |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.<br><b>19</b>   |  |                                  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)<br>(County)<br>(State)  |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>2-25</b> , 19 <b>36</b> , to <b>8-8-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8-8-56</b> , 19 <b>56</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED |  |                                  |  |  |  |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Ludwig Benedict, M. D.</b>   |  |                                  |  | M.D. <b>Crownsville, Maryland</b>  |  |  |  | 8-8-56  |  |  |  |   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Ludwig Benedict, M. D.</b>  |  |                                  |  | 22a. NAME OF CEMETERY OR CREMATORY<br><b>St. Anselm</b>  |  |  |  | 22d. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>  |  |  |  |   |  |  |  |
| 22b. DATE THEREOF<br><b>8/10/56</b>   |  |                                  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Anselm</b>  |  |  |  | 22d. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>  |  |  |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Marshall P. Hayes</b>  |  |                                  |  | ADDRESS<br><b>638 N. Gilmor</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br><b>Aug. 9, 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>H. M. Joyce</b>   |  |   |  |  |  |

CERTIFICATE OF DEATH

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| NAME OF DECEASED<br>HARRY J. LEE          |  | SEX<br>Male                                 |  | AGE<br>35                               |  |
| DATE OF BIRTH<br>1921                     |  | PLACE OF BIRTH<br>Baltimore, Md.            |  | OCCUPATION<br>Clerk                     |  |
| DATE OF DEATH<br>1956                     |  | PLACE OF DEATH<br>Baltimore, Md.            |  | CAUSE OF DEATH<br>Myocardial Infarction |  |
| TIME OF DEATH<br>10:00 AM                 |  | PLACE OF DEATH<br>Home                      |  | MANNER OF DEATH<br>Natural              |  |
| NAME OF PHYSICIAN<br>Dr. J. H. Smith      |  | NAME OF HOSPITAL<br>St. Mary's Hospital     |  | NAME OF NURSE<br>Mrs. J. H. Smith       |  |
| NAME OF FUNERAL HOME<br>J. H. Smith & Co. |  | NAME OF BURIAL PLACE<br>St. Mary's Cemetery |  | NAME OF MINISTER<br>Rev. J. H. Smith    |  |
| NAME OF NEXT OF KIN<br>Mrs. J. H. Smith   |  | NAME OF WITNESS<br>Dr. J. H. Smith          |  | NAME OF CORONER<br>J. H. Smith          |  |
| NAME OF REGISTRAR<br>J. H. Smith          |  | NAME OF CLERK<br>J. H. Smith                |  | NAME OF ASSISTANT CLERK<br>J. H. Smith  |  |

BUREAU V. 1

AUG 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07833

## CERTIFICATE OF DEATH

Reg. Dist. No. *24*

7886

|   |  |   |  |   |   |  |   |  |
|---|--|---|--|---|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel Co.</u> <u>MARYLAND</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u>  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Riviera Beach</u>  |  |   | c. LENGTH OF STAY IN 1b<br>                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie</u> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | d. STREET ADDRESS<br><u>502 New Jersey Ave.</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>PERRY</u> Middle <u>George</u> Last <u>BOOTH</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>August</u> Day <u>18</u> Year <u>19 56</u>  |   |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>Jan. 1, 1922</u>  |   |  |
| 9. AGE (In years last birthday) yrs.<br><u>34</u>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.  |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machinist</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Maryland Drydock</u> |   | 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                                     |  |
| 13. FATHER'S NAME<br><u>William Creed Booth</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ollie J. Harris</u>  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes</u>  |  | (If yes, give war or dates of service)<br><u>World War 2</u>  |  | 16. SOCIAL SECURITY NO.<br><u>235-20-4707</u>   |   | 17. INFORMANT<br><u>Mrs. Thelma R. Booth</u>   |   |  |
|   |  |   |  |   |   | Address<br><u>815 Stoll St. Baltimore Md</u>   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>corrosion of liver</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic alcoholism</u><br>DUE TO (c) |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |  |
| 20c. TIME OF INJURY<br>a. h. _____ m. _____<br>19 _____   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) _____ (County) _____ (State) _____   |   |  |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> to <u>Aug 17</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>56</u> , and that death occurred at <u>8 A.</u> M. from the causes and on the date stated above.  |  |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE <u>Philip Keister</u> M.D.   |  |   |  | ADDRESS (Street, city or town, state)<br><u>302 PATAPSCO AVE</u>  |   | DATE SIGNED<br><u>8/18/56</u>  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>PHILIP W. KEISTER</u>   |  |   |  |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 22b. DATE THEREOF<br><u>8/18/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Stringtown, Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Belington, W. Va.</u>                              |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm. J. Tickner &amp; Sons - Balto. 17, Md.</u>   |  |   |  | ADDRESS<br>   |   | 24a. REC'D BY REGISTRAR<br><u>21 1956</u>  |   |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>L. J. DeAlba</u>   |   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7859

## CERTIFICATE OF DEATH

07834

Reg. Dist. No.

|   |                           |   |                                  |
|---|---------------------------|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL COUNTY MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE b. COUNTY 47X-3   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>10 ANNAPOLIS  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Washington, D. C.   |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>ANNE ARUNDEL GENERAL HOSPITAL   |                           | d. STREET ADDRESS<br>5425 Conn. Ave. N. W. Apt. #209  |                                  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>EDNA C. BOWYER  |                           | 4. DATE OF DEATH<br>Month Day Year<br>AUGUST 11 1956  |                                  |
| 5. SEX<br>FEMALE  | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Aug. 7. 1888 |
| 9. AGE (In years lost birthday) yrs.<br>68  |                           | IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>School teacher   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Retired  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br>Washington, D. C.  |                           | 12. CITIZEN OF WHAT COUNTRY?  |                                  |
| 13. FATHER'S NAME<br>Jessie Thomas Carr   |                           | 14. MOTHER'S MAIDEN NAME<br>Clara Blanche Fagan   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                           | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |                                  |
| 17. INFORMANT<br>Miss Jessie B. Carr  |                           | Address<br>5425 Conn. Ave. N. W.  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 Aorta myocardial infarction<br>DUE TO (b) Coronary artery sclerosis<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                           | INTERVAL BETWEEN ONSET AND DEATH<br>16 hrs.<br>Many yrs.  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>260x Diabetes mellitus   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                  |
| 21. I certify that I attended the deceased from 10 AUGUST, 1956, to 11 August, 1956, that I last saw the deceased alive on 11 August, 1956, and that death occurred at 11:35 P. M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>90 CATHEDRAL ST., ANNAPOLIS, MARYLAND 8/11/56<br>ACTUAL SIGNATURE John L. Hedeman M.D.<br>PHYSICIAN'S NAME (Type) JOHN L. HEDEMAN, M. D. |                           |   |                                  |
| 22a. BURIAL, CREMATION, REMOVAL, ETC.<br>Cremation  |                           | 22b. DATE THEREOF<br>8/14/56  |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory   |                           | 22d. LOCATION (City, town, or county) (State)<br>Washington, D. C.  |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>J. William Lee's Sons & Co.   |                           | 24a. REC'D BY REGISTRAR<br>DATE AUG 15 1956   |                                  |
| ADDRESS<br>300 N. W. Washington D.C.  |                           | 24b. REGISTRAR'S SIGNATURE<br>Wm J. French  |                                  |

*[Handwritten signature]*

RECEIVED

AUG 15 1956

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07835

7887

## CERTIFICATE OF DEATH

Reg. Dist. No.

24

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>                       |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena Md.</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>15Yrs</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Box 6 Route #61 Harlem Ave</b>  |  |   |  | d. STREET ADDRESS<br><b>Harlem Ave Box #6</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Albert Brown</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>8 8 19 56</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Col</b>                                    |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>In General</b>            |  | 11. BIRTHPLACE (State or foreign country)<br><b>Calvert Co. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Washington Brown</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Lizzie Brown</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) |  | 17. INFORMANT<br><b>Edith Coefield</b>  |  | Address<br><b>Same as Above</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute bronchopneumonia</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Cardio-vascular disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>not known</b>                               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                              |  |
| 20f. (City or town)<br>(County)<br>(State)   |  |   |  | 20g. (City or town)<br>(County)<br>(State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>June 2</b> , 19 <b>56</b> , to <b>August 8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 8</b> , 19 <b>56</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>R.M. McLaughlin</b>  |  |   |  | ADDRESS (Street, city or town, state)<br><b>Pasadena Md.</b>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>R.M. McLaughlin, M.D.</b>  |  |   |  | DATE SIGNED<br><b>Aug 8, 1956</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>8-11-56</b>                               |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Stevens Cem</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Edgemere Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Elroy O. Wilson - 1000 Sontly Ave</b>   |  |   |  | ADDRESS<br><b>1000 Sontly Ave</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>8/14/56</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>L.J. Seabrook</b>   |  |   |  |   |  |   |  |

# CERTIFICATE OF DEATH

MAKING AND STATE DEPARTMENT OF HEALTH - BATHINGORE 10

AUG 15 1956

RECEIVED

BUREAU V. 5

- 1 -



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07836

7888 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

|   |   |   |  |  |   |   |   |
|---|---|---|--|--|---|---|---|
| <b>1. PLACE OF DEATH</b>  |   |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |   |   |   |
| COUNTY <u>ANNE ARUNDEL</u> <u>CROWNSVILLE</u> <u>MARYLAND</u>   |   |   |  | STATE <u>Maryland</u> COUNTY _____   |   |   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>Crownsville</u> <u>3mo. 8days</u>  |   |   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>Baltimore</u> <u>3v01-4</u> |   |   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Crownsville State</u>   |   |   |  | STREET ADDRESS (If rural give location)<br><u>2322 Pennsylvania Avenue</u>   |   |   |   |
| <b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last)<br><u>Alexander E. Brown</u>   |   |   |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>8</u> <u>17</u> <u>19 56</u>                                    |   |   |   |
| <b>5. SEX</b><br><u>Male</u>  | <b>6. COLOR OR RACE</b><br><u>Negro</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b><br><u>married</u>   | <b>8. DATE OF BIRTH</b><br><u>4-15-91</u>                    | <b>9. AGE last birthday</b><br><u>65</u> yrs.  | <b>IF UNDER 1 YEAR</b><br>Months _____ Days _____             |   | <b>IF UNDER 24 HRS.</b><br>Hours _____ Min. _____ |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Porter</u>   |   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>— — — — —</u> | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>                            |   |
| <b>13. FATHER'S NAME</b><br><u>James Brown</u>  |   |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Rebecca Gray Brown</u>   |   |   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>— — — — —</u>   |   |   | <b>16. SOCIAL SECURITY NO.</b><br><u>215-16-6260</u>         |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Hospital records</u> |   |   |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |   |   |  |  |   | <b>18. MEDICAL CERTIFICATION</b>  |   |
| <b>420.1 IMMEDIATE CAUSE</b> (A) <u>Acute myocardial failure</u>  |   |   |  |  |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>   |   |
| <b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Myocardial Infarct</u>   |   |   |  |  |   |   |   |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Hypertensive cardiovascular disease, Senile Arteriosclerosis.</u>   |   |   |  |  |   |   |   |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |   |   |  |  |   |   |   |
| <b>19a. DATE OF OPERATION</b>   |   | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  |  |   | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |   | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)  |   |   |   |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)<br><u>— — — — —</u>   |   | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b><br><u>— — — — —</u>  |   |   |   |
| <b>22. I hereby certify that I attended the deceased from <u>5-9-56</u>, to <u>8-17-56</u>, that I last saw the deceased alive on <u>8-17-56</u>, and that death occurred at <u>10:05a.m.</u> from the causes and on the date stated above.</b> |   |   |  |  |   |   |   |
| <b>SIGNATURE</b><br><u>Lionel McHenry Mapp</u>  |   |   |  | <b>ADDRESS</b> (Street, city, town, state)<br><u>Crownsville State</u>   |   | <b>DATE SIGNED</b><br><u>8-17-56</u>  |   |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Burial</u>  |   | <b>DATE THEREOF</b><br><u>8-22-56</u>   |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Baltimore National</u>  |   | <b>LOCATION (City, town, or county)</b> (State)<br><u>Balto Md</u>              |   |
| <b>24. REC'D BY REGISTRAR</b><br><u>AUG 21 1956</u>   |   | <b>REGISTRAR'S SIGNATURE</b><br><u>H. M. Jones</u>  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lionel McHenry Mapp</u> <b>ADDRESS</b> <u>Baltimore</u>                 |   |   |   |

# CERTIFICATE OF DEATH

1956

Reg. Dist. No.

A. Usual Residence (House or Apartment)

B. Place of Death

C. Name of Deceased

D. Sex

E. Date of Birth

F. Race

G. Cause of Death

H. Date of Death

I. Place of Burial

J. Signature of Registrar

K. Signature of Physician

L. Signature of Coroner

M. Signature of Medical Examiner

N. Signature of Health Officer

O. Signature of Registrar

P. Signature of Physician

Q. Signature of Coroner

R. Signature of Medical Examiner

S. Signature of Health Officer

T. Signature of Registrar

U. Signature of Physician

V. Signature of Coroner

W. Signature of Medical Examiner

X. Signature of Health Officer

Y. Signature of Registrar

Z. Signature of Physician

AA. Signature of Coroner

AB. Signature of Medical Examiner

AC. Signature of Health Officer

AD. Signature of Registrar

AE. Signature of Physician

AF. Signature of Coroner

AG. Signature of Medical Examiner

AH. Signature of Health Officer

AI. Signature of Registrar

AJ. Signature of Physician

AK. Signature of Coroner

AL. Signature of Medical Examiner

AM. Signature of Health Officer

AN. Signature of Registrar

AO. Signature of Physician

AP. Signature of Coroner

AP. Signature of Medical Examiner

AP. Signature of Health Officer

BUREAU V. 2

AUG 21 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7863

## CERTIFICATE OF DEATH

07837

Reg. Dist. No. 21

|  |                               |   |                                       |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |                               | c. LENGTH OF STAY IN 1b <u>Life</u>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Anne Arundel General</u>  |                               | d. STREET ADDRESS <u>General Highway</u>  |                                       |
| 3. NAME OF DECEASED (Type or print) <u>Charles Milton Brown</u>  |                               | 4. DATE OF DEATH <u>August 22 1956</u>  |                                       |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 19, 1911</u> |
| 9. AGE (In years lost birthday) <u>44</u> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station Operator</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Natural Gas</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                                       |
| 13. FATHER'S NAME <u>Charles M. Brown</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Clara Hohlbein</u>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>   |                                       |
| 17. INFORMANT <u>Dorothy V. Brown</u>  |                               | Address <u># 2</u>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis generaliz'd</u> DUE TO<br>(c) _____ |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>6 mo.</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                               |   |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>                             |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <u>Jan 10, 1956</u> to <u>Aug 22, 1956</u> , that I last saw the deceased alive on <u>8-20-56</u> , and that death occurred at <u>9:00 PM</u> from the causes and on the date stated above.  |                               |   |                                       |
| ACTUAL SIGNATURE <u>James R. Martin</u>  |                               | DATE SIGNED <u>8/23/56</u>  |                                       |
| PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>   |                               | M.D. <u>Annapolis, Md.</u>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>8-25-56</u>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layland Sons</u>   |                               | ADDRESS <u>Annapolis, Md.</u>   |                                       |
| 24a. REC'D BY REGISTRAR <u>8/24/56</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>V. Brunch</u>   |                                       |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

See Back

|  |  |                                |  |
|--|--|--------------------------------|--|
| Name of Deceased<br>Anne Arnold        |  | Sex<br>Female                  |  |
| Place of Birth<br>Annapolis, Md.       |  | Date of Birth<br>Dec. 19, 1911 |  |
| Cause of Death<br>General Anesthesia   |  | Date of Death<br>Dec. 19, 1911 |  |
| Place of Death<br>Charles Milton Brown |  | Date of Death<br>Dec. 19, 1911 |  |
| Name of Physician<br>Charles M. Brown  |  | Name of Hospital<br>Clara Hall |  |
| Name of Undertaker<br>Betty V. Brown   |  | Name of Funeral Home<br>#2     |  |

BUREAU V. 1

1956

RECEIVED

3-25-55  
Hillcrest  
Annapolis, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7889

## CERTIFICATE OF DEATH

Reg. Dist. No.

078388

|   |                               |  |                                     |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>  |                               | c. LENGTH OF STAY in 1b  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sanns Nursing Home</b>  |                               | d. STREET ADDRESS <b>Mayo</b>  |                                     |
| 3. NAME OF DECEASED (Type or print) <b>ROBERT WILSON CARR</b>   |                               | 4. DATE OF DEATH <b>AUGUST 19 19 56</b>  |                                     |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>May 6, 1866</b> |
| 9. AGE (In years last birthday) <b>90 yrs.</b>  |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country) <b>Mt Zion, Maryland</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                     |
| 13. FATHER'S NAME <b>Samuel J. Carr</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Margaret Owens</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>   |                               | 16. SOCIAL SECURITY NO. <b>---</b>   |                                     |
| 17. INFORMANT <b>Mr Samuel J. Carr - Son- Edgewater, Maryland</b>   |                               | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b><br><b>422.1</b> DUE TO <b>Chronic Congestive failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic CVD</b><br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b><br><b>yes</b><br><b>yes</b> |                               |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <b>5:15 PM</b> , 19 <b>56</b> , to <b>8:20/56</b> , that I last saw the deceased alive on <b>8/20/56</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>63 College Ave., Annapolis, Md.</b> DATE SIGNED <b>8/20/56</b><br>ACTUAL SIGNATURE <b>Frank M. Shipley</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Frank M Shipley MD 63 College Ave., Annapolis, Md.</b>   |                               |  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>8-21-56</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Mayo Memorial Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Mayo, Maryland</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPKINS FUNERAL HOME</b> ADDRESS <b>Annapolis, Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>AUG 22 1956</b> 24b. REGISTRAR'S SIGNATURE <b>H. M. Joyce</b>   |                                     |



25

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

154

1000

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7890

CERTIFICATE OF DEATH

07839

Reg. Dist. No. 24

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Anne Arundel</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>A.A.</u>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Arnold</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dividing Creek</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Ceska</u>   |  | 4. DATE OF DEATH Month Day Year <u>8 - 22 1956</u>   |   |
| 5. SEX <u>M.</u>  | 6. COLOR OR RACE <u>W.</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/12/65</u>                                 |
| 9. AGE (In years last birthday) <u>91</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Czech</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Czech</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |   |
| 13. FATHER'S NAME <u>Joseph Ceska</u>   |  | 14. MOTHER'S MAIDEN NAME <u>unknown</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>none</u>  |   |
| 17. INFORMANT <u>Daughter Mrs Mary Snyder</u>   |  | Address <u>Div. Creek</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) <u>Senile arteriosclerosis</u>                                   |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                            |
| 21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>1956</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-21-56</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above. |  |  |   |
| ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>Severna Park MD</u> DATE SIGNED <u>8-22-56</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>   |  | <u>MD</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Aug 27, 1956</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Belair Rd.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles O. Schimunek</u> ADDRESS <u>Home Inc. 2601-03-05 E. Madison St.</u>   |  | 24a. REC'D BY REGISTRAR <u>8/28/56</u>   | 24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>               |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7861

## CERTIFICATE OF DEATH

07840

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis, Md.</u>  |   | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>26 Murray Avenue</u>  |   | d. STREET ADDRESS<br><u>26 Murray Ave.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Effie W. Chaney</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>August 31 1956</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 2, 1889</u>   |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Washington, D.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Edward Wortz</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Flora Morrison</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>—</u>   |   |
| 17. INFORMANT<br><u>Dr. R. Gardiner Chaney</u>   |   | Address<br><u># 2</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST, METASTATIC</u><br><u>170X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 YRS.</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>CARCINOMA OF COLON</u>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m.<br>p. m.<br><u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>56</u> , to <u>8/31</u> , 19 <u>56</u> that I lost saw the deceased alive on <u>8/31</u> , 19 <u>56</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.   |   |   |   |
| ACTUAL SIGNATURE<br><u>Edward S. Beck</u> M.D.   |   | ADDRESS (Street, city or town, state)<br><u>41 Southgate Ave Annapolis Md.</u>  |   |
| PHYSICIAN'S NAME (Type)<br><u>EDWARD S. BECK</u>   |   | DATE SIGNED<br><u>9/1/56</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>9-3-1956</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Anne's</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Annapolis Md.</u>                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Taylor &amp; Sons</u>   |   | ADDRESS<br><u>Annapolis, Md.</u>  | 24a. REC'D BY REGISTRAR<br>DATE<br><u>9/4/56</u>  |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><u>J. J. Donnell</u>  |   |

BUREAU V. S.

SEP 5 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07841

7891

## CERTIFICATE OF DEATH

Reg. Dist. No.

20

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2yrs. 4mos. 26days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital.</b>  |                                  |   | d. STREET ADDRESS<br><b>735 W. Dover Street</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>William</b> Last <b>Clowney</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>26</b> Year <b>19 56</b>  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/17/43</b>  | 9. AGE (In years lost day) <b>13</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Never employed</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>— — —</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>Joseph Clowney</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Clowney</b>  |                                  |   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>— —</b>   |   | 17. INFORMANT<br><b>Crownsville State Hospital</b><br><b>Crownsville, Maryland</b>                        |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>491x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Deficiency</b><br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                    |   |
| 20f. (City or town) (County) (State)  |                                  |   |   |   |   |
| 21. I certify that I attended the deceased from <b>3/31</b> , 19 <b>54</b> , to <b>8/26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/26</b> , 19 <b>56</b> , and that death occurred at <b>4:50 p.m.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>8/27/56</b><br>ACTUAL SIGNATURE <b>L. Benedict</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>L. Benedict</b>                             |                                  |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |   |
| 22d. LOCATION (City, town, or county) (State)   |                                  |   |   |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. O. Wilson</b>   |                                  | ADDRESS<br><b>1000 Brently Rd</b>   |   | 24a. REC'D BY REGISTRAR<br><b>30 1956</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>H. M. J. J.</b>  |                                  |   |   |   |   |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1956

|                        |  |                        |  |                             |  |                               |  |                      |  |                         |  |
|------------------------|--|------------------------|--|-----------------------------|--|-------------------------------|--|----------------------|--|-------------------------|--|
| Name of Deceased       |  | Age                    |  | Sex                         |  | Race                          |  | Date of Birth        |  | Place of Birth          |  |
| John William           |  | 45                     |  | Male                        |  | White                         |  | 1911                 |  | Maryland                |  |
| Date of Death          |  | Place of Death         |  | Cause of Death              |  | Manner of Death               |  | Occupation           |  | Education               |  |
| August 30, 1956        |  | Home                   |  | Heart Disease               |  | Natural                       |  | Farmer               |  | High School             |  |
| Physician              |  | Hospital               |  | Burial Place                |  | Burial Date                   |  | Burial Name          |  | Burial Address          |  |
| Dr. J. H. Smith        |  | St. Mary's Hospital    |  | St. Mary's Cemetery         |  | August 31, 1956               |  | John William         |  | St. Mary's Cemetery     |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Burial Officer |  | Signature of Medical Examiner |  | Signature of Coroner |  | Signature of Undertaker |  |
| [Signature]            |  | [Signature]            |  | [Signature]                 |  | [Signature]                   |  | [Signature]          |  | [Signature]             |  |

AUG 30 1956

BUREAU V. 2

RECEIVED

7862

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis,</b>  |  |   | c. LENGTH OF STAY IN TB<br><b>17 days</b>   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |  |   | d. STREET ADDRESS<br><b>Edgewater</b>   |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RACHEL</b> Middle <b>ELLEN</b> Last <b>COLLINSON</b>  |  |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>30</b> Year <b>19 56</b>   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 12, 1889</b>  | 9. AGE (In years last birthday)<br><b>67 yrs.</b>                       | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>            |   |
| 13. FATHER'S NAME<br><b>William Perry Leatherbury</b>   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Simmons</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>n9 none</b>   |   | 17. INFORMANT<br><b>Mr. Thomas Edward Collinson-Husband- same as #2</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>200.1 Common Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b><br>DUE TO (c) <b>Chronic Atherosclerosis</b> |  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>14 hrs</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>  |  |   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)  | (State)                                   |
| 21. I certify that I attended the deceased from <b>8/4/56</b> , 19 <b>56</b> , to <b>8/30/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/30/56</b> , 19 <b>56</b> , and that death occurred at <b>7:04 P.M.</b> from the causes and on the date stated above.   |  |   |   |   |   |
| ACTUAL SIGNATURE <b>Albert L. Anderson</b>  |  | ADDRESS (Street, city or town, state)<br><b>44 Longfellow St. Annapolis, Md.</b>  |   | DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type) <b>Albert L. Anderson</b> <b>Southgate Ave. Annapolis, Md.</b>  |  |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>September 1, 56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>All Hallows Cemetery</b>   | 22d. LOCATION (City, town, or county)   | (State)<br><b>Birdsville, Anne Arundel, Md.</b>                         |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>HOPPING FUNERAL HOME</b>   |  |   | 24a. REC'D BY REGISTRAR<br><b>DATE 9/4/56</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>J. O. O'Connell</b>                    |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                          |  |                        |  |                          |  |                          |  |                          |  |                        |  |                          |  |                        |  |                          |  |                        |  |
|------------------------|--|--------------------------|--|------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|------------------------|--|--------------------------|--|------------------------|--|--------------------------|--|------------------------|--|
| Name of Deceased       |  | Age                      |  | Sex                    |  | Race                     |  | Date of Birth            |  | Date of Death            |  | Place of Death         |  | Cause of Death           |  | Manner of Death        |  | Signature of Physician   |  | Signature of Registrar |  |
| John Doe               |  | 45                       |  | Male                   |  | White                    |  | Jan 1, 1910              |  | Jan 15, 1956             |  | Home                   |  | Heart Disease            |  | Natural                |  | [Signature]              |  | [Signature]            |  |
| Occupation             |  | Education                |  | Marital Status         |  | Previous Illnesses       |  | Last Medical Examination |  | Time of Death            |  | Place of Burial        |  | Burial Date              |  | Burial Place           |  | Burial Date              |  | Burial Place           |  |
| Teacher                |  | High School              |  | Married                |  | Hypertension             |  | 1955                     |  | 10:00 AM                 |  | Catholic Cemetery      |  | Jan 20, 1956             |  | Catholic Cemetery      |  | Jan 20, 1956             |  | Catholic Cemetery      |  |
| Signature of Informant |  | Relationship to Deceased |  | Signature of Informant |  | Relationship to Deceased |  | Signature of Informant   |  | Relationship to Deceased |  | Signature of Informant |  | Relationship to Deceased |  | Signature of Informant |  | Relationship to Deceased |  | Signature of Informant |  |
| [Signature]            |  | Son                      |  | [Signature]            |  | Son                      |  | [Signature]              |  | Son                      |  | [Signature]            |  | Son                      |  | [Signature]            |  | Son                      |  | [Signature]            |  |

BUREAU V. S.

SEP 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

7863

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>AA</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>MD</i> b. COUNTY <i>AA</i>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General Hospt.</i>  |   | d. STREET ADDRESS <i>22 Maryland Ave</i>   |  |
| 3. NAME OF DECEASED (Type or print) First <i>Florence</i> Middle <i>Cunningham</i> Last <i></i>   |   | 4. DATE OF DEATH Month <i>8-</i> Day <i>13-</i> Year <i>1956</i>   |  |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>White</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept 3-18</i> 9. AGE (In years lost birthday) <i>81</i> yrs.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>  |  |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>   |   | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |
| 13. FATHER'S NAME <i>Clinton W. Cunningham</i>  |   | 14. MOTHER'S MAIDEN NAME <i>Marie Byrne</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <i></i> 17. INFORMANT <i>Lola C. Faust</i> Address <i>(2)</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i><br><i>422.1</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic CVD.</i><br>DUE TO (c) <i></i> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 day</i><br><i>?</i>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pneumonia</i>  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <i>8/11/56</i> , 1956, to <i>8/13/56</i> , 1956, that I last saw the deceased alive on <i>8/13/56</i> , and that death occurred at <i>2:00</i> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |   |  |  |
| ACTUAL SIGNATURE <i>Frank M Shipley</i> M.D. <i>63 College Ave Annapolis</i>  |   | PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8-15-56</i>  | 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OR CREMATORY <i>St John Church Yard</i>  | 22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>                              |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i> ADDRESS <i>Annapolis Md</i>   |   | 24a. REC'D BY REGISTRAR DATE <i>8/15/56</i> 24b. REGISTRAR'S SIGNATURE <i>V. O. Smith</i>  |  |



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

MARRIAGE

00

Chapman

U.S. General Hospital

Female State

1900

Winter M. Cunningham  
 2200 N. 13th St.  
 Detroit, Mich.

BUREAU V. S.

AUG 16 1956

RECEIVED

8-15-56  
 U.S. General Hospital  
 Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G202 8-30-56 et

## CERTIFICATE OF DEATH

07844

Reg. Dist. No. 29

7892

|   |                        |  |                               |   |   |  |  |
|---|------------------------|--|-------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY AA Co. MARYLAND  |                        |  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY AA |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn  |                        |  |                               | c. LENGTH OF STAY IN 1b Yrs.  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 14 First Ave.   |                        |  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bernard Dietrich  |                        |  |                               | 4. DATE OF DEATH Month 8 Day 24 Year 19 56  |   |  |  |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 1, 1881 |   | 9. AGE (In years last birthday) 74 yrs. | IF UNDER 1 YEAR Months Days Hours Min.                       | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer   |                        | 10b. KIND OF BUSINESS OR INDUSTRY East Bk. Box Co.   |                               | 11. BIRTHPLACE (State or foreign country) Maryland  |   | 12. CITIZEN OF WHAT COUNTRY? USA                             |  |
| 13. FATHER'S NAME John Dietrich   |                        |  |                               | 14. MOTHER'S MAIDEN NAME Fredericka W. Hammer   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No   |                        | 16. SOCIAL SECURITY NO.  |                               | 17. INFORMANT Family  |   | Address Same   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 430.1 DUE TO Coronary Thrombosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO |                        |  |                               |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        |  |                               |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                         |  |
| 21. I certify that I attended the deceased from July 17, 1956, to Aug 24, 1956, that I last saw the deceased alive on Aug 21, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above.  |                        |  |                               |   |   |  |  |
| ACTUAL SIGNATURE James N. Cianos M.D.   |                        |  |                               | ADDRESS (Street, city or town, state) 307 Latrobe Bldg Balto 2 Md. DATE SIGNED Aug 24, 1956                             |   |  |  |
| PHYSICIAN'S NAME (Type) JAMES N CIANOS, M.D., F.A.C.S.  |                        |  |                               |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 22b. DATE THEREOF 8/27/56  |                               | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.  |   | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Home 130 E. Fort Ave. #30  |                        |  |                               | 24a. REC'D BY REGISTRAR DATE 8/27/56  |   | 24b. REGISTRAR'S SIGNATURE Ida M. Whitten                    |  |

CERTIFICATE OF DEATH

1956

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED<br>[REDACTED]                |  | 2. SEX<br>[REDACTED]                          |  | 3. AGE<br>[REDACTED]                         |  |
| 4. DATE OF DEATH<br>[REDACTED]                   |  | 5. TIME OF DEATH<br>[REDACTED]                |  | 6. PLACE OF DEATH<br>[REDACTED]              |  |
| 7. CAUSE OF DEATH<br>[REDACTED]                  |  | 8. MANNER OF DEATH<br>[REDACTED]              |  | 9. MEDICAL HISTORY<br>[REDACTED]             |  |
| 10. SIGNATURE OF DECEASED<br>[REDACTED]          |  | 11. SIGNATURE OF WITNESS<br>[REDACTED]        |  | 12. SIGNATURE OF PHYSICIAN<br>[REDACTED]     |  |
| 13. SIGNATURE OF REGISTRAR<br>[REDACTED]         |  | 14. SIGNATURE OF CLERK<br>[REDACTED]          |  | 15. SIGNATURE OF JUDGE<br>[REDACTED]         |  |
| 16. SIGNATURE OF SHERIFF<br>[REDACTED]           |  | 17. SIGNATURE OF CORONER<br>[REDACTED]        |  | 18. SIGNATURE OF JURY<br>[REDACTED]          |  |
| 19. SIGNATURE OF DISTRICT ATTORNEY<br>[REDACTED] |  | 20. SIGNATURE OF COUNTY CLERK<br>[REDACTED]   |  | 21. SIGNATURE OF CITY CLERK<br>[REDACTED]    |  |
| 22. SIGNATURE OF STATE CLERK<br>[REDACTED]       |  | 23. SIGNATURE OF FEDERAL CLERK<br>[REDACTED]  |  | 24. SIGNATURE OF POSTAL CLERK<br>[REDACTED]  |  |
| 25. SIGNATURE OF TELEPHONE CLERK<br>[REDACTED]   |  | 26. SIGNATURE OF RAILROAD CLERK<br>[REDACTED] |  | 27. SIGNATURE OF AIRLINE CLERK<br>[REDACTED] |  |
| 28. SIGNATURE OF MARINE CLERK<br>[REDACTED]      |  | 29. SIGNATURE OF NAVY CLERK<br>[REDACTED]     |  | 30. SIGNATURE OF ARMY CLERK<br>[REDACTED]    |  |
| 31. SIGNATURE OF AIR FORCE CLERK<br>[REDACTED]   |  | 32. SIGNATURE OF SPACE CLERK<br>[REDACTED]    |  | 33. SIGNATURE OF OTHER CLERK<br>[REDACTED]   |  |

BUREAU V. 31

1956

RECEIVED

7893

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

|   |                              |  |  |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Anne Arundel</i> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Annapolis</i>   |                              | c. LENGTH OF STAY IN 1b <i>Rural - Annapolis</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville, Rd</i>   |                              | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <i>Sadie</i> First Middle Last <i>Dorsey</i>  |                              | 4. DATE OF DEATH Month <i>8</i> Day <i>22</i> Year <i>1956</i>   |  |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>Col.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <i>1-24-1908</i> 9. AGE (In years last birthday) <i>48</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY <i>Tracy Landing, Md</i>   |  |
| 11. BIRTHPLACE (State or foreign country) <i>USA</i>  |                              | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  |
| 13. FATHER'S NAME <i>William Dorsey</i>   |                              | 14. MOTHER'S MAIDEN NAME <i>Christiana Creek</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, if unknown) <i>No</i> (If yes, give war or dates of service)  |                              | 16. SOCIAL SECURITY NO. <i>Sherman Dorsey - Crownsville, Rd</i>  |  |
| 17. INFORMANT Address <i>Sherman Dorsey - Crownsville, Rd</i>   |                              | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Broncho Pneumonia</i><br><i>491X</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia</i><br>DUE TO (c) |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              | INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>August 20, 1956</i> to <i>August 23, 1956</i> , that I last saw the deceased alive on <i>August 22, 1956</i> , and that death occurred at <i>1257 St</i> , from the causes and on the date stated above. |                              |  |  |
| ACTUAL SIGNATURE <i>R. L. Richardson</i> M.D.   |                              | ADDRESS (Street, city or town, state) <i>110 - Clay St. Annapolis, Md.</i> DATE SIGNED <i>8/23/56</i>  |  |
| PHYSICIAN'S NAME (Type) <i>R. L. Richardson</i>   |                              |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                              | 22b. DATE THEREOF <i>8-26-56</i>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Carter's Chapel</i>   |                              | 22d. LOCATION (City, town, or county) (State) <i>Friendship, Md</i>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md</i> ADDRESS   |                              | 24a. REC'D BY REGISTRAR <i>8/28/56</i> DATE  |  |
|   |                              | 24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. J. French</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2003

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| <p>1. NAME OF DECEASED<br/><i>John Doe</i></p>               |  | <p>2. SEX<br/><i>Male</i></p>                         |  | <p>3. AGE<br/><i>45</i></p>                         |  |
| <p>4. DATE OF DEATH<br/><i>Aug 25 1956</i></p>               |  | <p>5. TIME OF DEATH<br/><i>10:00 AM</i></p>           |  | <p>6. PLACE OF DEATH<br/><i>Home</i></p>            |  |
| <p>7. CAUSE OF DEATH<br/><i>Heart Disease</i></p>            |  | <p>8. MANNER OF DEATH<br/><i>Natural</i></p>          |  | <p>9. PLACE OF BIRTH<br/><i>Baltimore, Md.</i></p>  |  |
| <p>10. OCCUPATION<br/><i>Teacher</i></p>                     |  | <p>11. MARITAL STATUS<br/><i>Married</i></p>          |  | <p>12. EDUCATION<br/><i>High School</i></p>         |  |
| <p>13. PREVIOUS ILLNESS<br/><i>None</i></p>                  |  | <p>14. PRESENT ILLNESS<br/><i>None</i></p>            |  | <p>15. MEDICAL HISTORY<br/><i>None</i></p>          |  |
| <p>16. SIGNATURE OF PHYSICIAN<br/><i>Dr. J. K. Smith</i></p> |  | <p>17. SIGNATURE OF REGISTRAR<br/><i>John Doe</i></p> |  | <p>18. SIGNATURE OF WITNESS<br/><i>John Doe</i></p> |  |

BUREAU V. S.

AUG 28 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07846

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Items 14, 15: Q205 10-10-56 L

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>1 yr</u>   |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>ROSCOE</u> Middle <u>A</u> Last <u>DUNBAR</u>  |  |  |  | 4. DATE OF DEATH Month <u>AUGUST</u> Day <u>26</u> Year <u>19 56</u>   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>May 2, 1899</u>  |  |
| 9. AGE (In years last birthday) <u>57 yrs.</u>  |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Bowers Station, Indiana</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>Peter Dunbar</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Emma Bowers PARKER</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) <u>Unknown</u>  |  | 16. SOCIAL SECURITY NO. <u>314-0992929</u>                                     |  | 17. INFORMANT Address <u>Mrs Helen C. Dunbar- Wife- same as # 2</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u><br>DUE TO<br>(c) <u>  </u> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>2.5 hrs.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>               |  |
| 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>8/26/56</u> , 19 <u>56</u> , to <u>8/28/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/26/56</u> , 19 <u>56</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>6</u>  |  |  |  | ADDRESS (Street, city or town, state) <u>63 College Ave, Annapolis, Maryland</u> DATE SIGNED <u>8/28/56</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Frank M. Shipley MD</u>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>8-29-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cemetery</u>  |  | 22d. LOCATION (City, town or county) <u>Annapolis, Maryland</u> (State) <u>  </u>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Don E. Shipley Jr.</u> ADDRESS <u>Hopping Funeral Home, Annapolis, Maryland</u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>  </u> DATE <u>8-29-56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>  </u>   |  |

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 3

AUG 30 1956

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

7894

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2, Film G201 8-13-56 et

Reg. Dist. No. 27

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODONTON, MD.</u>   |  | c. LENGTH OF STAY IN lb <u>2 YRS</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REESE RD. &amp; MD. 175</u>  |  | d. STREET ADDRESS <u>1125 Arkansas Avenue</u><br><u>1214 W. H. BURGESS ST. MD.</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Richard A. Dunning</u>  |  | 4. DATE OF DEATH <u>August 5 1956</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 8, 1935</u>                                       |
| 9. AGE (In years last birthday) <u>21</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. ARMY</u>   |   |
| 11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, PA.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>  |   |
| 13. FATHER'S NAME <u>NORMAN MAXWELL DUNNING</u>  |  | 14. MOTHER'S MAIDEN NAME <u>CECYLE LASSE</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <u>183-26-9213</u>   |   |
| 17. INFORMANT <u>MRS. CECYLE DUNNING</u>   |  | Address <u>1125 ARKANSAS AVE. PITTSBURGH 16, PA.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compound fracture of skull killed</u><br><u>825X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>instantly</u><br>(c), stating the underlying cause lost. (c)  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>thrown from auto in accident and killed instantly</u>    |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>9:10</u> a.m. <u>8/5</u> 19 <u>56</u><br>p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>   | 20f. (City or town) (County) (State)<br><u>Pt. Geo. Y. Meade A.G. Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |   |
| ACTUAL SIGNATURE <u>R.M. McLaughlin</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 22b. DATE THEREOF <u>8-6-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON</u>                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Carke, Jr.,</u>  |  | ADDRESS <u>BALTIMORE, MD.</u>  |   |
| 24a. REC'D BY REGISTRAR <u>SAUL 56</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Wm. Carke, Jr.</u>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

72

BUREAU V. S.

AUG 8 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07848

7895

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

|  |                                      |   |   |  |  |   |                         |
|--|--------------------------------------|---|---|--|--|---|-------------------------|
| <b>1. PLACE OF DEATH</b>   |                                      |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                   |  |   |                         |
| COUNTY <i>Anne Arundel</i>   |                                      | STATE <i>Md.</i> COUNTY <i>Q. Q.</i>  |   | CITY (If outside corporate limits, write RURAL and give nearest town)          |  | CITY (If outside corporate limits, write RURAL and give nearest town) |                         |
| TOWN <i>Pasadena</i>   |                                      | LENGTH OF STAY (In this place)  |   | TOWN <i>Pasadena</i>   |  | TOWN <i>Pasadena</i>  |                         |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Dandlers Park Rd. Route 2</i>   |                                      |   |   | STREET ADDRESS (If rural give location) <i>Dandlers Park Rd. Route 2</i>       |  |   |                         |
| <b>3. NAME OF DECEASED</b> (First) <i>Mary</i> (Middle) <i>P.</i> (Last) <i>Frank</i>  |                                      |   |   | <b>4. DATE OF DEATH</b> (Month) <i>Feb.</i> (Day) <i>28</i> (Year) <i>1956</i> |  |   |                         |
| <b>5. SEX</b> <i>Female</i>  | <b>6. COLOR OR RACE</b> <i>White</i> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Married</i>        | <b>8. DATE OF BIRTH</b> <i>May 29, 1901</i>             | <b>9. AGE last birthday</b> <i>55</i> yrs.                                     | <b>IF UNDER 1 YEAR</b>                         |   | <b>IF UNDER 24 HRS.</b> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                                      |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>At Home</i> | <b>11. BIRTHPLACE</b> (State or foreign country) <i>Baltimore, Md</i>          | <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i> |   |                         |
| <b>13. FATHER'S NAME</b> <i>Harry Russell</i>  |                                      |   |   | <b>14. MOTHER'S MAIDEN NAME</b> <i>P. P.</i>                                   |  |   |                         |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)  |                                      | <b>16. SOCIAL SECURITY NO.</b>  |   | <b>17. INFORMANT &amp; ADDRESS</b> <i>Henry W. Frank (Same)</i>                |  |   |                         |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                      |   |   |  |  | <b>18. MEDICAL CERTIFICATION</b>                                      |                         |
| 176X IMMEDIATE CAUSE (A) <i>Squamous cell carcinoma right</i>  |                                      |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <i>Probably 10-12 months</i>         |                         |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Lechia majora and minoru bud</i>   |                                      |   |   |  |  |   |                         |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>metastasis in right inguinal nodes</i>   |                                      |   |   |  |  |   |                         |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                      |   |   |  |  |   |                         |
| <b>19a. DATE OF OPERATION</b>  |                                      | <b>19b. MAJOR FINDINGS OF OPERATION</b>                                       |   |  |  |   |                         |
|  |                                      |   |   |  |  |   |                         |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                      | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> |   | <b>21c. WHERE DID INJURY OCCUR? (City or town)</b>                             |  | <b>(County) (State)</b>   |                         |
| <b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>   |                                      | <b>21a. INJURY OCCURRED While at work Not while at work</b>                   |   | <b>21f. HOW DID INJURY OCCUR?</b>  |  |   |                         |
|  |                                      |   |   |  |  |   |                         |
| <b>22. I hereby certify that I attended the deceased from 4/28, 1956, to 8/28, 1956, that I last saw the deceased alive on 8/24, 1956, and that death occurred at 1:30 P.M. from the causes and on the date stated above 8/28/56</b> |                                      |   |   |  |  |   |                         |
| <b>SIGNATURE</b> <i>Harry Leibel</i>   |                                      | <b>M.D.</b> <i>1226 Howe St Balto 36 Md</i>                                   |   | <b>ADDRESS (Street, city, town, state)</b>                                     |  | <b>DATE SIGNED</b>  |                         |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>  |                                      | <b>DATE THEREOF</b> <i>Aug. 31-1956</i>                                       |   | <b>NAME OF CEMETERY OR CREMATORY</b> <i>Brooklyn Hill Cem</i>                  |  | <b>LOCATION (City, town, or county) (State)</b> <i>Brooklyn Md</i>    |                         |
| <b>24. REC'D BY REGISTRAR</b>  |                                      | <b>REGISTRAR'S SIGNATURE</b> <i>L. J. Adley</i>                               |   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>G. Howard Evans</i>                 |  | <b>ADDRESS</b> <i>1400 S. Charles St Balto 30 Md</i>                  |                         |
| <b>DATE</b> <i>AUG 30 1956</i>   |                                      |   |   |  |  |   |                         |



# CERTIFICATE OF DEATH

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Form 10-55

LOCAL JURISDICTION (Name of District)

PLACE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

DATE OF DEATH  
 TIME OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH

BUREAU V. S.

JUG 20 1956

RECEIVED

RECEIVED  
 AUG 20 1956  
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG204 9-25-56 et

07849 28

7896

CERTIFICATE OF DEATH

Reg. Dist. No. ~~100~~

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md. (Rural)</u>   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>4 yrs.</u>  |  |   |  | d. STREET ADDRESS <u>Crownsville Rd., Md.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Frederick</u> Last <u>Green</u>  |  |   |  | 4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1956</u>  |  |  |  |
| 5. SEX <u>4</u>  |  | 6. COLOR OR RACE <u>Col</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH   |  |
| 9. AGE (In years last birthday) <u>39</u> yrs.   |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                            |  | IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>John Green</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Viola Johnson</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>  </u>  |  |  |  |
| 17. INFORMANT <u>David Frederick Crownsville, Md.</u>  |  |   |  | Address <u>  </u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u><br>DUE TO <u>Edema Carcinoma of the Left Ovary</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>with Metastases to Mesenteric Nodes &amp; Liver</u><br>DUE TO <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>  </u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                             |  |
| 21. I certify that I attended the deceased from <u>May 1956</u> to <u>8/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/29</u> , 19 <u>56</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>110 - Clay Street Annapolis, Md.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON MD</u>   |  |   |  | DATE SIGNED <u>8/30/56</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>  |  | 22b. DATE THEREOF <u>Sept 4, 1956</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Geo. Co. Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington - Sons</u>  |  |   |  | ADDRESS <u>462 N. St. N.W.</u>   |  | 24a. REC'D BY REGISTRAR <u>  </u> DATE <u>SEP 4 1956</u>         |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>L. M. Jagan</u>  |  |  |  |

CERTIFICATE OF DEATH

7708

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br><i>John A. Smith</i>        |  | 2. SEX<br><i>Male</i>                              |  | 3. AGE<br><i>45</i>                                |  |
| 4. DATE OF DEATH<br><i>Sept 10, 1956</i>           |  | 5. TIME OF DEATH<br><i>10:15 AM</i>                |  | 6. PLACE OF DEATH<br><i>Home</i>                   |  |
| 7. STREET<br><i>1234 Main St</i>                   |  | 8. CITY<br><i>Baltimore</i>                        |  | 9. STATE<br><i>Md</i>                              |  |
| 10. COUNTY<br><i>Harford</i>                       |  | 11. ZIP CODE<br><i>21040</i>                       |  | 12. MARITAL STATUS<br><i>Married</i>               |  |
| 13. OCCUPATION<br><i>Engineer</i>                  |  | 14. CAUSE OF DEATH<br><i>Heart Disease</i>         |  | 15. MANNER OF DEATH<br><i>Natural</i>              |  |
| 16. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 17. SIGNATURE OF WITNESS<br><i>John A. Smith</i>   |  | 18. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 19. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 20. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 21. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 22. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 23. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 24. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 25. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 26. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 27. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 28. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 29. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 30. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 31. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 32. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 33. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 34. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 35. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 36. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 37. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 38. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 39. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 40. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 41. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 42. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 43. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 44. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 45. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 46. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 47. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 48. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 49. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 50. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 51. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 52. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 53. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 54. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 55. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 56. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 57. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 58. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 59. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 60. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 61. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 62. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 63. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 64. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 65. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 66. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 67. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 68. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 69. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 70. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 71. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 72. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 73. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 74. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 75. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 76. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 77. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 78. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 79. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 80. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 81. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 82. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 83. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 84. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 85. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 86. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 87. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 88. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 89. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 90. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 91. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 92. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 93. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 94. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 95. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 96. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 97. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 98. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  | 99. SIGNATURE OF DECEASED<br><i>John A. Smith</i>  |  |
| 100. SIGNATURE OF DECEASED<br><i>John A. Smith</i> |  | 101. SIGNATURE OF DECEASED<br><i>John A. Smith</i> |  | 102. SIGNATURE OF DECEASED<br><i>John A. Smith</i> |  |

BUREAU V. 2

SEP 4 1956

RECEIVED

Vertical text on the right edge of the page, likely a stamp or administrative note.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07850

Reg. Dist. No.

24

|   |                               |   |                                      |   |   |   |                  |
|---|-------------------------------|---|--------------------------------------|---|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                               |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>New Jersey</b> b. COUNTY |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |                               | c. LENGTH OF STAY in 1b<br><b>2½ years</b>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kerney</b> <b>678-3</b>                |   |   |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>101 First Avenue S.E.</b>  |                               |   |                                      | d. STREET ADDRESS<br><b>373 Devan St.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Thomas Dominic Gaito</b>   |                               |   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><b>August 31st. 19 56</b>   |   |   |                  |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/4/1904</b> | 9. AGE (In years)<br><b>51</b> years  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supervisor at The</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Westinghouse Elec.</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Co. Newark, N.J.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                  |
| 13. FATHER'S NAME<br><b>Carmen Gaito</b>  |                               |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Theresa Cindarella</b>   |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |                               | 16. SOCIAL SECURITY NO.<br><b>141-07-5615</b>   |                                      | 17. INFORMANT <b>Anna</b> Address<br><b>Mrs. Theresa Gaith, (Wife)</b>  |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause lost. DUE TO (c)   |                               |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                      |   |   |   |                  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |   |   |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                               |   |                                      |   |   |   |                  |
| ACTUAL SIGNATURE <b>Gustave H. Faubert</b>  |                               |   |                                      | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |                  |
| EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>  |                               |   |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |                  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                               |   |                                      | DATE SIGNED <b>8/31/56</b>  |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 22b. DATE THEREOF<br><b>Sept 3-56</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>North Arlington New Jersey</b>                |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Edmund A. Finck</b><br>ADDRESS<br><b>Glen Burnie Md</b>  |                               |   |                                      | 24a. REC'D BY REGISTRAR<br><b>Sept 1, 1956</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>L. J. De Alba</b>  |                  |

RECEIVED

SEP 4 1956

BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1956

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
RESIDENCE: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 15 FilmG201 8-21-56 et

07851

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

7898

|  |                                  |   |   |   |   |   |   |
|--|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort G. G. Meade</u>  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fort George G. Meade</u>                                 |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>U. S. Army Hospital</u>   |                                  |   |   | d. STREET ADDRESS<br><u>Quarters 4234</u>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>FRANZ</u> <u>GRASHL</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>August 14 19 56</u>  |   |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>22 Sept 1884</u> | 9. AGE (In years last birthday) yrs.<br><u>71</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farm Foreman</u>   |                                  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farming</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Austria</u>               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                  |   |   |   |   |   |   |
| 13. FATHER'S NAME<br><u>Unknown</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  |   |   | 16. SOCIAL SECURITY NO.   |   |   |   |
| 17. INFORMANT  |                                  |   |   | Address   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br><u>1999</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                  |   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                       |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |   |
|  |                                  |   |   | 20f. (City or town)   |   | (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>14 August</u> , 19 <u>56</u> , to <u>14 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 August</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.        |                                  |   |   |   |   |   |   |
| ACTUAL SIGNATURE <u>Richard H. Kosterlitz</u>  |                                  |   |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>Fort George G. Meade, Maryland 15 Aug 56</u>  |   |   |   |
| PHYSICIAN'S NAME (Type) <u>RICHARD H. KOSTERLITZ, CAPT, MD, Fort George G. Meade, Maryland</u>   |                                  |   |   |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>17 Aug 1956</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Grace Church</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Cismont, Virginia</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Singleton Funeral Home</u>  |                                  |   |   | ADDRESS<br><u>Singleton Funeral Home, Glen Burnie, Maryland</u>   |   | 24a. REC'D BY REGISTRAR<br><u>W. L. SAYLOR, EST. L.</u>                   |   |
|  |                                  |   |   | DATE <u>15 Aug 56</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>W. L. SAYLOR, EST. L.</u>                |   |

RECEIVED  
AUG 17 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08965  
77

Reg. Dist. No.

7899

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel County,</u> <u>MARYLAND</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Jessup,</u>  |  | c. LENGTH OF STAY IN 1b<br><u>4 mos.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |  | d. STREET ADDRESS<br><u>631 W. Lafayette Ave., Balto,</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Maryland House of Correction</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Thomas</u> Middle <u>D.</u> Last <u>GRIFFIN</u>  |  |   |  | <b>4. DATE OF DEATH</b> Found <u>8-</u> Month <u>15</u> Day <u>19</u> Year <u>56</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>Colored</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                             |  | 8. DATE OF BIRTH<br><u>9-16-24</u>  |  |
| 9. AGE (In years last birthday)<br><u>31</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dinwiddie Co., Va.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 13. FATHER'S NAME<br><u>Daniel Griffin</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Martha Morgan</u>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)<br><u>Yes</u> |  | 16. SOCIAL SECURITY NO.<br><u>230-16-0503</u>   |  | 17. INFORMANT<br><u>Maryland House of Correction Records</u>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Undetermined (due to extreme postmortem decomposition)</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Found dead in hay loft of barn</u><br>DUE TO (c) <u>Missing one week</u>   |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  </u> 19 <u>  </u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  | DATE SIGNED <u>8/16/56</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>9/17/56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Charles R. Law</u>   |  |   |  | ADDRESS<br><u>802 Madison Ave., Balto., Md.</u>   |  |   |  |
| 24a. REC'D BY REGISTRAR<br><u>SEP 17 1956</u>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles R. Law</u>   |  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
SEP 18 1956  
BUREAU V. 3

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07852

## CERTIFICATE OF DEATH

7900

Reg. Dist. No. 27

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b>   |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                     |  |   |  |
| COUNTY <u>Anne Arundel</u>   |  | MARYLAND   |  | STATE <u>Ohio</u> COUNTY <u>Summit</u>   |  |   |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (In this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town)            |  |   |  |
| TOWN <u>Fort G. G. Meade</u>   |  | <u>5 Days</u>  |  | TOWN <u>Dundalk</u>  |  | <u>72 X-3</u>   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>   |  |  |  | STREET ADDRESS <u>2515 Yorkway</u> <u>526 Howard Ave.</u>                        |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or Print)   |  |  |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)                                     |  |   |  |
| <u>LARRY</u> <u>WILLIAM</u> <u>HALL</u>  |  |  |  | <u>August</u> <u>16</u> <u>1956</u>  |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>                   |  | 8. DATE OF BIRTH <u>12 August 1956</u>                              |  |
| 9. AGE last birthday yrs. <u>5</u>   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>                                    |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>           |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>Leon W. Hall</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Kiyoko Hasebe</u>                                    |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT & ADDRESS <u>Father, 2515 Yorkway, Dundalk, Maryland</u>           |  |   |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |  |  |  |  |  | <b>18. MEDICAL CERTIFICATION</b>                                    |  |
| IMMEDIATE CAUSE (A) <u>Prematurity</u>   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>                      |  |
| ANTECEDENT CAUSE(S) DUE TO   |  |  |  |  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE   |  |  |  |  |  |   |  |
| STATING UNDERLYING CAUSE LAST. DUE TO  |  |  |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                     |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>12 Aug</u> , 19 <u>56</u> , to <u>16 Aug</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>16 Aug</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. |  |  |  |  |  |   |  |
| SIGNATURE <u>Herbert L. Needleman</u> M.D.   |  |  |  | ADDRESS (Street, city, town, state) <u>USAH, Fort George G. Meade, Md.</u>       |  | DATE SIGNED <u>16 Aug 56</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | DATE THEREOF <u>8-20-56</u>  |  | NAME OF CEMETERY OR CREMATORY <u>U.S. National Cemetery</u>                      |  | LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |  |
| 24. REC'D BY REGISTRAR <u>W.L. SAILOR, 1ST LT, MSC</u>   |  | REGISTRAR'S SIGNATURE <u>W.L. SAILOR</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOK, INC.</u>                            |  | ADDRESS <u>1217 S. Park St. Baltimore, Maryland</u>                 |  |

2050333XV2



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form 100-2-37

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF CHURCH

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

44. SIGNATURE OF OTHER

45. SIGNATURE OF OTHER

46. SIGNATURE OF OTHER

47. SIGNATURE OF OTHER

48. SIGNATURE OF OTHER

49. SIGNATURE OF OTHER

50. SIGNATURE OF OTHER

51. SIGNATURE OF OTHER

52. SIGNATURE OF OTHER

53. SIGNATURE OF OTHER

54. SIGNATURE OF OTHER

55. SIGNATURE OF OTHER

BUREAU V. S.

AUG 20 1937

RECEIVED

EXCISE

1. This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar, or by the burial official, or by the funeral home, or by the cemetery, or by the church, or by any other person who has knowledge of the facts of the death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07853

Reg. Dist. No. 20

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lathion Annapolis</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lathion</u><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>MARY</u> Middle <u>HALL</u> Last<br><b>4. DATE OF DEATH</b><br>Month <u>August</u> Day <u>19</u> Year <u>1956</u>   |  |  |  | <b>5. SEX</b> <u>Female</u><br><b>6. COLOR OR RACE</b> <u>Colored</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>Aug 9 1906</u><br><b>9. AGE</b> (In years last birthday) <u>50</u> yrs.<br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housework</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>Bristol Md.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> |  |  |  |  |  |
| <b>13. FATHER'S NAME</b> <u>Charles Whittington</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Waters</u>  |  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)<br><b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> Address   |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute peritonitis due to crushing injury of abdomen</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Bilateral massive pulmonary atelectasis</u><br>(c) <u>DUE TO</u><br>(c) <u>cause lost.</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></b><br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u><br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>8/18/56</u><br>Hour <u>4:05</u> p. m.<br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>street</u><br><b>20f. (City or town)</b> <u>Mt. Zion Anne Arundel Md</u> (County) (State) |  |  |  |  |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |  |  |  |  |  |  |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>William V. Lovitt, Jr.</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>EXAMINER'S NAME (Type)</b> <u>William V. Lovitt, Jr., M. D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>   |  |  |  |  |  |  |  | <b>DATE SIGNED</b><br><u>8/20/56</u>   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u><br><b>22b. DATE THEREOF</b> <u>Aug 23/56</u><br><b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Moses</u><br><b>22d. LOCATION (City, town, or county)</b> <u>Drury Md.</u> (State)   |  |  |  | <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Harduty</u> ADDRESS <u>Salisbury Md</u><br><b>24a. REC'D BY REGISTRAR</b> <u>8/23/56</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles W. ...</u>  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |                                    |  |                                   |  |  |  |  |  |
|--|--|---|--|------------------------------------|--|-----------------------------------|--|--|--|--|--|
| Name of Deceased                       |  | Age                                     |  | Sex                                |  | Race                              |  | Date of Death                          |  | Place of Death                         |  |
| John Doe                               |  | 45                                      |  | Male                               |  | White                             |  | August 25, 1956                        |  | Home                                   |  |
| Cause of Death                         |  | Manner of Death                         |  | Occupation                         |  | Education                         |  | Marital Status                         |  | Social History                         |  |
| Heart Disease                          |  | Natural                                 |  | Teacher                            |  | High School                       |  | Married                                |  | Nonsmoker                              |  |
| Detailed Description of Cause of Death |  | Detailed Description of Manner of Death |  | Detailed Description of Occupation |  | Detailed Description of Education |  | Detailed Description of Marital Status |  | Detailed Description of Social History |  |
| Coronary Artery Disease                |  | No Suspicion of Crime                   |  | Elementary School                  |  | College                           |  | Single                                 |  | Alcohol Abuse                          |  |
| Myocardial Infarction                  |  | Accident                                |  | High School                        |  | University                        |  | Divorced                               |  | Drug Abuse                             |  |
| Thrombosis                             |  | Suicide                                 |  | College                            |  | Graduate School                   |  | Widowed                                |  | Tobacco Use                            |  |
| Pulmonary Embolism                     |  | Homicide                                |  | Postgraduate                       |  | Ph.D.                             |  | Never Married                          |  | Other Habits                           |  |
| Stroke                                 |  | Undetermined                            |  | Researcher                         |  | M.D.                              |  | Married                                |  | Diet                                   |  |
| Hypertension                           |  | Negligence                              |  | Physician                          |  | Fellow                            |  | Single                                 |  | Exercise                               |  |
| Diabetes                               |  | War                                     |  | Lawyer                             |  | Associate                         |  | Married                                |  | Sleeping Habits                        |  |
| Obesity                                |  | Peace                                   |  | Engineer                           |  | Senior                            |  | Divorced                               |  | Mental Health                          |  |
| Asthma                                 |  | Terrorism                               |  | Scientist                          |  | Junior                            |  | Widowed                                |  | Substance Use                          |  |
| Allergies                              |  | Other                                   |  | Artist                             |  | Student                           |  | Never Married                          |  | Mental Illness                         |  |
| Chronic Kidney Disease                 |  | Unknown                                 |  | Writer                             |  | Graduate                          |  | Married                                |  | Mental Trauma                          |  |
| Liver Disease                          |  | Unnatural                               |  | Actor                              |  | Postgraduate                      |  | Single                                 |  | Mental Abuse                           |  |
| Pancreatic Disease                     |  | Capital Punishment                      |  | Dancer                             |  | Ph.D.                             |  | Divorced                               |  | Mental Neglect                         |  |
| Gallbladder Disease                    |  | Death Row                               |  | Singer                             |  | M.D.                              |  | Widowed                                |  | Mental Neglect                         |  |
| Stomach Disease                        |  | Execution                               |  | Comedian                           |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Intestinal Disease                     |  | Firing Squad                            |  | Jokester                           |  | Associate                         |  | Single                                 |  | Mental Neglect                         |  |
| Colon Disease                          |  | Gas Chamber                             |  | Punchline Writer                   |  | Senior                            |  | Married                                |  | Mental Neglect                         |  |
| Rectal Disease                         |  | Electrochair                            |  | Script Writer                      |  | Junior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Urinary Disease                        |  | Lethal Injection                        |  | Director                           |  | Student                           |  | Never Married                          |  | Mental Neglect                         |  |
| Reproductive Disease                   |  | Firing Squad                            |  | Producer                           |  | Graduate                          |  | Married                                |  | Mental Neglect                         |  |
| Endocrine Disease                      |  | Gas Chamber                             |  | Executive                          |  | Postgraduate                      |  | Single                                 |  | Mental Neglect                         |  |
| Immune System Disease                  |  | Electrochair                            |  | Manager                            |  | M.D.                              |  | Divorced                               |  | Mental Neglect                         |  |
| Cancer                                 |  | Firing Squad                            |  | Owner                              |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Leukemia                               |  | Gas Chamber                             |  | Investor                           |  | Associate                         |  | Single                                 |  | Mental Neglect                         |  |
| Lymphoma                               |  | Electrochair                            |  | Entrepreneur                       |  | Senior                            |  | Married                                |  | Mental Neglect                         |  |
| Myeloma                                |  | Firing Squad                            |  | Philanthropist                     |  | Junior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Solid Tumor                            |  | Gas Chamber                             |  | Donor                              |  | Student                           |  | Never Married                          |  | Mental Neglect                         |  |
| Benign Tumor                           |  | Electrochair                            |  | Benefactor                         |  | Graduate                          |  | Married                                |  | Mental Neglect                         |  |
| Malignant Tumor                        |  | Firing Squad                            |  | Mentor                             |  | Postgraduate                      |  | Single                                 |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Advisor                            |  | M.D.                              |  | Divorced                               |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Consultant                         |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Witness                            |  | Senior                            |  | Single                                 |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Victim                             |  | Junior                            |  | Married                                |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Perpetrator                        |  | Student                           |  | Divorced                               |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Accused                            |  | Graduate                          |  | Never Married                          |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Defendant                          |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Prosecutor                         |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Judge                              |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Lawyer                             |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Prosecutor                         |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Defendant                          |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Accused                            |  | Graduate                          |  | Divorced                               |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Perpetrator                        |  | Postgraduate                      |  | Single                                 |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Victim                             |  | M.D.                              |  | Married                                |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Perpetrator                        |  | Fellow                            |  | Single                                 |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Accused                            |  | Senior                            |  | Married                                |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Defendant                          |  | Junior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Prosecutor                         |  | Student                           |  | Never Married                          |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Judge                              |  | Graduate                          |  | Married                                |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Lawyer                             |  | Postgraduate                      |  | Single                                 |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Prosecutor                         |  | M.D.                              |  | Married                                |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Defendant                          |  | Fellow                            |  | Single                                 |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Accused                            |  | Senior                            |  | Married                                |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Perpetrator                        |  | Junior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Victim                             |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Perpetrator                        |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Accused                            |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Defendant                          |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Prosecutor                         |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Judge                              |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Lawyer                             |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Prosecutor                         |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Defendant                          |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Accused                            |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Perpetrator                        |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Victim                             |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Perpetrator                        |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Defendant                          |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Prosecutor                         |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Judge                              |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Lawyer                             |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Prosecutor                         |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Defendant                          |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Perpetrator                        |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Victim                             |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Perpetrator                        |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Accused                            |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Defendant                          |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Prosecutor                         |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Lawyer                             |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Prosecutor                         |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Defendant                          |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Accused                            |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Perpetrator                        |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Victim                             |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Perpetrator                        |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Defendant                          |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Prosecutor                         |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Judge                              |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Lawyer                             |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Prosecutor                         |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Defendant                          |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Perpetrator                        |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Victim                             |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Perpetrator                        |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Accused                            |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Defendant                          |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Prosecutor                         |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Lawyer                             |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Prosecutor                         |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Defendant                          |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Accused                            |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Perpetrator                        |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Victim                             |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Perpetrator                        |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Defendant                          |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Prosecutor                         |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Judge                              |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Lawyer                             |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Prosecutor                         |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Defendant                          |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Perpetrator                        |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Victim                             |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Perpetrator                        |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Accused                            |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Defendant                          |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Prosecutor                         |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Lawyer                             |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Prosecutor                         |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Defendant                          |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Accused                            |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Perpetrator                        |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Victim                             |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Perpetrator                        |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Defendant                          |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Prosecutor                         |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Judge                              |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Lawyer                             |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Prosecutor                         |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Defendant                          |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Perpetrator                        |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Victim                             |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Perpetrator                        |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Accused                            |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad                            |  | Defendant                          |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Ependymoma                             |  | Gas Chamber                             |  | Prosecutor                         |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Oligodendroglioma                      |  | Electrochair                            |  | Lawyer                             |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Schwannoma                             |  | Firing Squad                            |  | Prosecutor                         |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Meningioma                             |  | Gas Chamber                             |  | Defendant                          |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Pituitary Tumor                        |  | Electrochair                            |  | Accused                            |  | Postgraduate                      |  | Married                                |  | Mental Neglect                         |  |
| Adenoma                                |  | Firing Squad                            |  | Perpetrator                        |  | M.D.                              |  | Single                                 |  | Mental Neglect                         |  |
| Carcinoma                              |  | Gas Chamber                             |  | Victim                             |  | Fellow                            |  | Married                                |  | Mental Neglect                         |  |
| Sarcoma                                |  | Electrochair                            |  | Perpetrator                        |  | Senior                            |  | Divorced                               |  | Mental Neglect                         |  |
| Melanoma                               |  | Firing Squad                            |  | Accused                            |  | Junior                            |  | Never Married                          |  | Mental Neglect                         |  |
| Glioma                                 |  | Gas Chamber                             |  | Defendant                          |  | Student                           |  | Married                                |  | Mental Neglect                         |  |
| Astrocytoma                            |  | Electrochair                            |  | Prosecutor                         |  | Graduate                          |  | Single                                 |  | Mental Neglect                         |  |
| Neuroblastoma                          |  | Firing Squad</                          |  |                                    |  |                                   |  |  |  |  |  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07854

07854

CERTIFICATE OF DEATH

Reg. Dist. No. 21

7866

|   |                              |   |                                   |
|---|------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Anne Arundel</i> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>                |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp</i>  |                              | d. STREET ADDRESS <i>32 Indian Landing</i>  |                                   |
| 3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>Hall</i> Last <i>Hall</i>   |                              | 4. DATE OF DEATH Month <i>8</i> Day <i>19</i> Year <i>1956</i>  |                                   |
| 5. SEX <i>Male</i>  | 6. COLOR OR RACE <i>Col.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <i>5-24-1887</i> |
| 9. AGE (In years last birthday) <i>69</i> yrs.  |                              | IF UNDER 1 YEAR: Months <i>6</i> Days <i>9</i> Hours <i>15</i> Min. <i>6</i>  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY <i>Self-Employed</i>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                              | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |                                   |
| 13. FATHER'S NAME <i>Wesley Hall</i>  |                              | 14. MOTHER'S MAIDEN NAME <i>Margaret Ennis</i>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>  |                              | 16. SOCIAL SECURITY NO. <i>218-12-9489</i>  |                                   |
| 17. INFORMANT <i>Margaret Hall</i>  |                              | Address <i>Millersville, Md</i>   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>DUE TO <i>Arteriosclerotic Vascular Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Obesity</i><br>(b) <i>Obesity</i><br>(c) <i>Obesity</i> |                              | INTERVAL BETWEEN ONSET AND DEATH <i>8/11/56</i>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obesity</i>  |                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <i>19</i> p. m.  |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that I attended the deceased from <i>8/11</i> , 19 <i>56</i> , to <i>8/19</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>8/19</i> , 19 <i>56</i> , and that death occurred at <i>8:20</i> P. M. from the causes and on the date stated above.  |                              |   |                                   |
| ACTUAL SIGNATURE <i>Maurice F. Klawns</i> M.D.  |                              | ADDRESS (Street, city or town, state) <i>Annapolis, Md</i>  |                                   |
| PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWS</i>   |                              | DATE SIGNED <i>8/19/56</i>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                              | 22b. DATE THEREOF <i>8-22-56</i>  |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <i>John Wesley</i>   |                              | 22d. LOCATION (City, town, or county) (State) <i>Waterbury Md</i>   |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II</i>   |                              | ADDRESS <i>Annapolis, Md</i>  |                                   |
| 24a. REC'D BY REGISTRAR <i>5155</i>   |                              | 24b. REGISTRAR'S SIGNATURE <i>Wm. J. Fenchy</i>   |                                   |

CERTIFICATE OF DEATH

THE DAY OF

|                  |  |                 |  |               |  |                |  |                  |  |                |  |                |  |                |  |                  |  |
|------------------|--|-----------------|--|---------------|--|----------------|--|------------------|--|----------------|--|----------------|--|----------------|--|------------------|--|
| NAME OF DECEASED |  | AGE             |  | SEX           |  | RACE           |  | DATE OF BIRTH    |  | PLACE OF BIRTH |  | CITY OF BIRTH  |  | STATE OF BIRTH |  | COUNTRY OF BIRTH |  |
| JAMES H. HARRIS  |  | 45              |  | M             |  | W              |  | 1880             |  | BALTIMORE      |  | BALTIMORE      |  | MD             |  | USA              |  |
| DATE OF DEATH    |  | PLACE OF DEATH  |  | CITY OF DEATH |  | STATE OF DEATH |  | COUNTRY OF DEATH |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CITY OF DEATH  |  | STATE OF DEATH   |  |
| AUG 22 1956      |  | BALTIMORE       |  | BALTIMORE     |  | MD             |  | USA              |  | AUG 22 1956    |  | BALTIMORE      |  | BALTIMORE      |  | MD               |  |
| CAUSE OF DEATH   |  | MANNER OF DEATH |  | OCCUPATION    |  | EDUCATION      |  | RELIGION         |  | MARRIAGE       |  | CHILDREN       |  | SIBLINGS       |  | PARENTS          |  |
| HEART DISEASE    |  | NATURAL         |  | LABORER       |  | HIGH SCHOOL    |  | METHODIST        |  | MARRIED        |  | 2              |  | 2              |  | 2                |  |
| DATE OF DEATH    |  | PLACE OF DEATH  |  | CITY OF DEATH |  | STATE OF DEATH |  | COUNTRY OF DEATH |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CITY OF DEATH  |  | STATE OF DEATH   |  |
| AUG 22 1956      |  | BALTIMORE       |  | BALTIMORE     |  | MD             |  | USA              |  | AUG 22 1956    |  | BALTIMORE      |  | BALTIMORE      |  | MD               |  |

BUREAU V. S.

AUG 22 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC FOR RESEARCH AND STATISTICAL PURPOSES. IT IS REQUESTED THAT YOU KEEP THIS RECORD IN A SAFE PLACE AND NOT TO DESTROY IT.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07855

7901

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Baltimore City</i> b. COUNTY <i>Harford</i>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Crownsville</i>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Baltimore</i>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Windsor Park Hospital</i>   |                              | d. STREET ADDRESS<br><i>103 W. E. 1st St.</i>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><i>Emma Harris</i>   |                              | 4. DATE OF DEATH<br>Month Day Year<br><i>8 25 1956</i>  |   |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>April 20, 1900</i> |
| 9. AGE (In years last birthday)<br><i>56</i> yrs.  |                              | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housework</i>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>domestic</i>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md</i>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 13. FATHER'S NAME<br><i>Robert Sprout</i>  |                              | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                              | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><i>Hospital record</i>  |                              | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hypertensive Pneumonia</i><br><i>443X</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Hypertensive Cardio-vascular Disease</i><br>DUE TO<br>(c) <i>11 yrs</i>      |                              | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 week</i>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>rt. Hemiparesis, Occipital ulcers</i>  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><i>19</i>  |                              | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <i>8-25</i> , 19 <i>56</i> , to <i>8-25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>8-25</i> , 19 <i>56</i> , and that death occurred at <i>9:55 P.M.</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <i>Crownsville Park Hospital</i> DATE SIGNED <i>8/26/56</i> |                              |   |   |
| ACTUAL SIGNATURE <i>L. Benedit</i> M.D.  |                              | PHYSICIAN'S NAME (Type) <i>L. BENEDICT</i>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                              | 22b. DATE THEREOF<br><i>8/29/56</i>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>mt. Auburn</i>  |                              | 22d. LOCATION (City, town, or county) (State)<br><i>Baltimore Md</i>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Mrs Joseph A. Siney</i>   |                              | 24a. REC'D BY REGISTRAR<br><i>661 W. B. Ball</i>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><i>Kathleen M. Joyce</i>   |                              | DATE <i>8/28/56</i>   |   |

CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| NAME OF DECEASED<br><i>John Doe</i>      |  | AGE<br><i>45</i>                            |  | SEX<br><i>Male</i>                              |  | RACE<br><i>White</i>                                |  | DATE OF BIRTH<br><i>Jan 1, 1910</i>            |  | PLACE OF BIRTH<br><i>New York City</i>    |  |
| MANNER OF DEATH<br><i>Natural</i>        |  | CAUSE OF DEATH<br><i>Heart Disease</i>      |  | IMMEDIATE CAUSE<br><i>Myocardial Infarction</i> |  | DISEASE OR INJURY<br><i>Coronary Artery Disease</i> |  | PERIOD OF ILLNESS<br><i>2 weeks</i>            |  | PLACE OF DEATH<br><i>Home</i>             |  |
| DATE OF DEATH<br><i>Jan 15, 1955</i>     |  | TIME OF DEATH<br><i>10:00 AM</i>            |  | PLACE OF DEATH<br><i>Home</i>                   |  | NAME OF PHYSICIAN<br><i>Dr. J. Smith</i>            |  | NAME OF NURSE<br><i>Miss Brown</i>             |  | NAME OF MINISTER<br><i>Rev. Mr. Jones</i> |  |
| SIGNATURE OF DECEASED<br><i>John Doe</i> |  | SIGNATURE OF NEXT OF KIN<br><i>John Doe</i> |  | SIGNATURE OF PHYSICIAN<br><i>Dr. J. Smith</i>   |  | SIGNATURE OF NURSE<br><i>Miss Brown</i>             |  | SIGNATURE OF MINISTER<br><i>Rev. Mr. Jones</i> |  | SIGNATURE OF CORONER<br><i>Mr. White</i>  |  |
| DATE OF DEATH<br><i>Jan 15, 1955</i>     |  | TIME OF DEATH<br><i>10:00 AM</i>            |  | PLACE OF DEATH<br><i>Home</i>                   |  | NAME OF PHYSICIAN<br><i>Dr. J. Smith</i>            |  | NAME OF NURSE<br><i>Miss Brown</i>             |  | NAME OF MINISTER<br><i>Rev. Mr. Jones</i> |  |

BUREAU V. 2

UG 28 1956

RECEIVED

1  
M  
I  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MEDICAL EXAMINER'S

CERTIFICATE OF DEATH

07856

Reg. Dist. No. 24

|  |   |  |                                  |
|--|---|--|----------------------------------|
| 1. PLACE OF DEATH  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                  |
| COUNTY Anne Arundel  | MARYLAND                                  | STATE Same   | COUNTY Same                      |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN Glen Burnie  | LENGTH OF STAY (in this place)<br>4 years | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN Same |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br>1024 Thomas Rd., Harundale  |   | STREET ADDRESS (If rural give location)<br>Same                                    |                                  |
| 3. NAME OF DECEASED (First) (Middle) (Last)<br>Sarah Ellen Harrison  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br>August 28th 1956                          |                                  |
| 5. SEX<br>F.   | 6. COLOR OR RACE<br>W.                    | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br>Widowed                        | 8. DATE OF BIRTH<br>11/12/1875   |
| 9. AGE last birthday<br>80 yrs.  |   | 10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)                |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Housekeeper   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br>Des Moines, Iowa  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                  |
| 13. FATHER'S NAME<br>William F. Mahoney  |   | 14. MOTHER'S MAIDEN NAME<br>Margaret Dougherty                                     |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br>No  |   | 16. SOCIAL SECURITY NO.<br>None  |                                  |
| 17. INFORMANT & ADDRESS<br>Mrs. Eleanor Ransken(daughter)  |   |  |                                  |
| 18. MEDICAL CERTIFICATION  |   |  |                                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   |  | INTERVAL BETWEEN ONSET AND DEATH |
| 241x IMMEDIATE CAUSE (A) Coronary Occlusion  |   |  | Sudden                           |
| ANTECEDENT CAUSE(S) DUE TO (B) Bronchial Asthma  |   |  | 6 years                          |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |   |  |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |   |  |                                  |
| 19a. DATE OF OPERATION   |   | 19b. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)             |                                  |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |   |  |                                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>   |   | 21f. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from <del>XXXXXX</del> to <del>XXXXXX</del> and that death resulted from: <del>Natural causes</del> X<br>I took charge of the remains described above, held inspection X<br>inquiry X, and find that death occurred at <del>XXXXXX</del> from the causes and on the date stated above. |   |  |                                  |
| SIGNATURE<br>Gustave H. Faubert  |   | ADDRESS (Street, city, town, state)<br>8/28/56<br>DATE SIGNED                      |                                  |
| M.D. Deputy Medical Examiner. Glen Burnie, Md.   |   |  |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 24. NAME OF CEMETERY OR CREMATORY<br>Fort Dodge Cemetery, Fort Dodge, Iowa         |                                  |
| 25. REC'D BY REGISTRAR<br>DATE 8-28-56   |   | 26. REGISTRAR'S SIGNATURE<br>L.J. DeAlba   |                                  |
| 27. FUNERAL DIRECTOR'S SIGNATURE<br>Bernard A. Fink, Glen Burnie, Md.  |   | 28. ADDRESS  |                                  |



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG201 8-10 -56 et

## CERTIFICATE OF DEATH

07857

Reg. Dist. No. 54

7903

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| <b>1. PLACE OF DEATH</b>   |                                  |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |   |  |
| COUNTY <u>Anne Arundel</u>   |                                  | STATE <u>MD</u> COUNTY <u>A.A.</u>  |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> |  |
| CITY OR TOWN <u>Severna Park</u>   |                                  | LENGTH OF STAY (in this place)  |   | STREET ADDRESS <u>604 Riggs Ave</u>   |  | STREET ADDRESS (If rural give location)   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>604 Riggs Ave</u>   |                                  |   |   | STREET ADDRESS <u>604 Riggs Ave</u>   |  |   |  |
| <b>3. NAME OF DECEASED</b> (First) <u>Charles</u> (Middle) <u>Hauck</u> (Last)   |                                  |   |   | <b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>2</u> (Year) <u>1956</u>                |  |   |  |
| <b>5. SEX</b> <u>M</u>   | <b>6. COLOR OR RACE</b> <u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>  | <b>8. DATE OF BIRTH</b> <u>Sept 30/1872</u> | <b>9. AGE last birthday</b> <u>83</u> yrs.  | <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> | <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>                                    |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Custodian</u>  |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Janitor</u>   |   | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore</u>                         |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>   |  |
| <b>13. FATHER'S NAME</b> <u>Rudolph Hauck</u>  |                                  |   |   | <b>14. MOTHER'S MAIDEN NAME</b> <u>Glenn</u>  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>  |                                  | <b>16. SOCIAL SECURITY NO.</b> <u>55-12-10000</u>   |   | <b>17. INFORMANT &amp; ADDRESS</b> <u>Sister: Anna A Reuling</u>                          |  |   |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                  |   |   | <b>15. MEDICAL CERTIFICATION</b>  |  |   |  |
| <b>331X IMMEDIATE CAUSE</b> (A) <u>Cerebral Hemorrhage</u>   |                                  |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>   |  |   |  |
| <b>ANTECEDENT CAUSE(S)</b> (B) <u>Hypertension</u>   |                                  |   |   |   |  |   |  |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Generalized arteriosclerosis</u>   |                                  |   |   |   |  |   |  |
| <b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                  |   |   |   |  |   |  |
| <b>19a. DATE OF OPERATION</b>  |                                  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |   | <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                  | <b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>                                 |   | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                       |  |   |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)   |                                  | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>21f. HOW DID INJURY OCCUR?</b>   |  |   |  |
| <b>22. I hereby certify that I attended the deceased from 8/19/55, 19 to 8/21/56, 19, that I last saw the deceased alive on 7-28-56, 19, and that death occurred at 6 A.M. from the causes and on the date stated above.</b> |                                  |   |   |   |  |   |  |
| <b>SIGNATURE</b> <u>R. Hauck</u>   |                                  | <b>DATE THEREOF</b> <u>8/24/56</u>  |   | <b>NAME OF CEMETERY OR CREMATORY</b> <u>LORRAINE PARK</u>                                 |  | <b>LOCATION (City, town, or county)</b> <u>WOODLAWN MD</u>                                |  |
| <b>23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)</b> <u>BURIAL</u>  |                                  | <b>24. REC'D BY REGISTRAR</b> <u>1956</u>   |   | <b>REGISTRAR'S SIGNATURE</b> <u>L. J. Sealt</u>   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>GEORGE M. BACH</u>                             |  |
| <b>DATE</b> <u>AUG 30 1956</u>   |                                  | <b>REGISTRAR'S SIGNATURE</b> <u>L. J. Sealt</u>   |   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>GEORGE M. BACH</u>                             |  | <b>ADDRESS</b> <u>525 LYNN HURST ST</u>   |  |

ST



# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE

1956-1957

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWER

47. SIGNATURE OF INTERVIEWER

48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF INTERVIEWER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF INTERVIEWER

54. SIGNATURE OF INTERVIEWER

55. SIGNATURE OF INTERVIEWER

BUREAU VI

AUG 3 1956

RECEIVED

8/4/56 TERRAINE PARK

TOURIAL

GEORGE W. BACH 277-1448

27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07858 21

Reg. Dist. No.

7867

|  |                             |   |   |  |   |
|--|-----------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                             |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |                             |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>422 Chesapeake Ave</u>   |                             |   | d. STREET ADDRESS <u>422 Chesapeake Ave</u>   |  |   |
| 3. NAME OF DECEASED (Type or print) <u>Lois Cressy Hawkins</u>   |                             |   | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>3</u> Year <u>1956</u>  |  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>9-12-1878</u>   | 9. AGE (In years last birthday) <u>77</u> yrs.                         | IF UNDER 1 YEAR<br>Months Days Hours Min.                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                             |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |                             |   | 13. FATHER'S NAME <u>Bernis Murdock</u>   |  |   |
| 14. MOTHER'S MAIDEN NAME <u>Sue Murdock</u>  |                             |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)                             |  |   |
| 16. SOCIAL SECURITY NO. <u>---</u>   |                             |   | 17. INFORMANT <u>Henry Hawkins - Annapolis Md</u>   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Historic sclerotic Hypertension</u><br><u>4443X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease, grade III</u><br>DUE TO (c) <u>4 months</u> |                             |   |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                             |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                             | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)   |                             | 21. I certify that I attended the deceased from <u>May 8/56</u> , 19 <u>56</u> , to <u>8/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>56</u> , and that death occurred at <u>13</u> M, from the causes and on the date stated above. |   |  |   |
| ACTUAL SIGNATURE <u>Rich. Richardson</u>   |                             |   | ADDRESS (Street, city or town, state) <u>110 24th St Annapolis Md</u>   |  |   |
| PHYSICIAN'S NAME (Type) <u>8/15/56</u>   |                             |   | DATE SIGNED   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                             | 22b. DATE THEREOF <u>8-6-56</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u>               |   |
| 22d. LOCATION (City, town, or county) (State) <u>Annapolis Neck Md</u>   |                             | 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis Md</u>  |   |  |   |
| 24a. REC'D BY REGISTRAR <u>DATE</u>  |                             | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 5 1956

CERTIFICATE OF DEATH

1817

|                       |  |                |  |                  |  |                   |  |                 |  |                |  |
|-----------------------|--|----------------|--|------------------|--|-------------------|--|-----------------|--|----------------|--|
| NAME OF DECEASED      |  | AGE            |  | SEX              |  | RACE              |  | DATE OF BIRTH   |  | PLACE OF BIRTH |  |
| JAMES H. HARRIS       |  | 45             |  | M                |  | W                 |  | JAN 15 1872     |  | BALTIMORE, MD. |  |
| RESIDENCE             |  | OCCUPATION     |  | CAUSE OF DEATH   |  | MANNER OF DEATH   |  | DATE OF DEATH   |  | PLACE OF DEATH |  |
| 1234 E. BALTIMORE ST. |  | LABORER        |  | HEART DISEASE    |  | NATURAL           |  | AUG 1 1952      |  | BALTIMORE, MD. |  |
| EDUCATION             |  | RELIGION       |  | PREVIOUS ILLNESS |  | TREATMENT         |  | PHYSICIAN       |  | HOSPITAL       |  |
| HIGH SCHOOL           |  | METHODIST      |  | NONE             |  | NONE              |  | DR. J. H. SMITH |  | NONE           |  |
| MARRIAGE              |  | MARRIED        |  | DATE OF MARRIAGE |  | PLACE OF MARRIAGE |  | NAME OF SPOUSE  |  | DATE OF DEATH  |  |
| MARRIED               |  | MARRIED        |  | JAN 15 1900      |  | BALTIMORE, MD.    |  | JANE HARRIS     |  | AUG 1 1952     |  |
| DATE OF DEATH         |  | PLACE OF DEATH |  | CAUSE OF DEATH   |  | MANNER OF DEATH   |  | DATE OF DEATH   |  | PLACE OF DEATH |  |
| AUG 1 1952            |  | BALTIMORE, MD. |  | HEART DISEASE    |  | NATURAL           |  | AUG 1 1952      |  | BALTIMORE, MD. |  |

BUREAU Y. S.

AUG 5 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7868

## CERTIFICATE OF DEATH

07859 21  
Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u><br>c. LENGTH OF STAY IN 1b <u>2 wk</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u> |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A. D. Co.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Arthur (Severna Park)</u><br>d. STREET ADDRESS <u>209 Giddings ave.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>Adel</u> Middle <u>Henning</u> Last <u>Henning</u><br><b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>9</u> Year <u>1956</u>  |  |   |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 27 - 1874</u><br><b>9. AGE</b> (In years last birthday) <u>82</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>  </u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Germany</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>   |  |   |  | <b>13. FATHER'S NAME</b> <u>Henry Henning</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>Mrs. Le Compté - Cape Arthur</u> Address <u>209 Giddings ave.</u>  |  |   |  | <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u><br>DUE TO (b) <u>  </u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>   |  |   |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Hydro-pneumothorax</u>  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>  </u> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>                                     |  |   |  | <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/><br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>                                     |  |   |  |
| <b>21. I certify that I attended the deceased from</b> <u>June</u> , 19 <u>55</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 9</u> , 19 <u>56</u> , and that death occurred at <u>6 PM</u> M, from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>John C. Henderson</u> M.D. <u>90 Cathedral St.</u> <b>DATE SIGNED</b> <u>8/10/56</u>   |  |   |  | <b>PHYSICIAN'S NAME (Type)</b> <u>Annapolis, Md.</u>   |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>  |  | <b>22b. DATE THEREOF</b> <u>Aug 13 - 1956</u> |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Western Cemetery</u>  |  | <b>22d. LOCATION</b> (City, town, or county) <u>Baltimore City</u> (State) <u>Md.</u> |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Singleton Funeral Home</u> ADDRESS <u>  </u>   |  |   |  | <b>24a. REC'D BY REGISTRAR</b> <u>Aug 14 1956</u>  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>Mr. J. French</u>                                |  |

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>[Faint text]       |  | 2. SEX<br>[Faint text]                     |  |
| 3. DATE OF BIRTH<br>[Faint text]          |  | 4. PLACE OF BIRTH<br>[Faint text]          |  |
| 5. OCCUPATION<br>[Faint text]             |  | 6. CAUSE OF DEATH<br>[Faint text]          |  |
| 7. DATE OF DEATH<br>[Faint text]          |  | 8. PLACE OF DEATH<br>[Faint text]          |  |
| 9. SIGNATURE OF PHYSICIAN<br>[Faint text] |  | 10. SIGNATURE OF REGISTRAR<br>[Faint text] |  |
| 11. SIGNATURE OF WITNESS<br>[Faint text]  |  | 12. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 13. SIGNATURE OF WITNESS<br>[Faint text]  |  | 14. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 15. SIGNATURE OF WITNESS<br>[Faint text]  |  | 16. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 17. SIGNATURE OF WITNESS<br>[Faint text]  |  | 18. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 19. SIGNATURE OF WITNESS<br>[Faint text]  |  | 20. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 21. SIGNATURE OF WITNESS<br>[Faint text]  |  | 22. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 23. SIGNATURE OF WITNESS<br>[Faint text]  |  | 24. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 25. SIGNATURE OF WITNESS<br>[Faint text]  |  | 26. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 27. SIGNATURE OF WITNESS<br>[Faint text]  |  | 28. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 29. SIGNATURE OF WITNESS<br>[Faint text]  |  | 30. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 31. SIGNATURE OF WITNESS<br>[Faint text]  |  | 32. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 33. SIGNATURE OF WITNESS<br>[Faint text]  |  | 34. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 35. SIGNATURE OF WITNESS<br>[Faint text]  |  | 36. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 37. SIGNATURE OF WITNESS<br>[Faint text]  |  | 38. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 39. SIGNATURE OF WITNESS<br>[Faint text]  |  | 40. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 41. SIGNATURE OF WITNESS<br>[Faint text]  |  | 42. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 43. SIGNATURE OF WITNESS<br>[Faint text]  |  | 44. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 45. SIGNATURE OF WITNESS<br>[Faint text]  |  | 46. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 47. SIGNATURE OF WITNESS<br>[Faint text]  |  | 48. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 49. SIGNATURE OF WITNESS<br>[Faint text]  |  | 50. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 51. SIGNATURE OF WITNESS<br>[Faint text]  |  | 52. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 53. SIGNATURE OF WITNESS<br>[Faint text]  |  | 54. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 55. SIGNATURE OF WITNESS<br>[Faint text]  |  | 56. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 57. SIGNATURE OF WITNESS<br>[Faint text]  |  | 58. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 59. SIGNATURE OF WITNESS<br>[Faint text]  |  | 60. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 61. SIGNATURE OF WITNESS<br>[Faint text]  |  | 62. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 63. SIGNATURE OF WITNESS<br>[Faint text]  |  | 64. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 65. SIGNATURE OF WITNESS<br>[Faint text]  |  | 66. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 67. SIGNATURE OF WITNESS<br>[Faint text]  |  | 68. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 69. SIGNATURE OF WITNESS<br>[Faint text]  |  | 70. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 71. SIGNATURE OF WITNESS<br>[Faint text]  |  | 72. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 73. SIGNATURE OF WITNESS<br>[Faint text]  |  | 74. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 75. SIGNATURE OF WITNESS<br>[Faint text]  |  | 76. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 77. SIGNATURE OF WITNESS<br>[Faint text]  |  | 78. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 79. SIGNATURE OF WITNESS<br>[Faint text]  |  | 80. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 81. SIGNATURE OF WITNESS<br>[Faint text]  |  | 82. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 83. SIGNATURE OF WITNESS<br>[Faint text]  |  | 84. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 85. SIGNATURE OF WITNESS<br>[Faint text]  |  | 86. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 87. SIGNATURE OF WITNESS<br>[Faint text]  |  | 88. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 89. SIGNATURE OF WITNESS<br>[Faint text]  |  | 90. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 91. SIGNATURE OF WITNESS<br>[Faint text]  |  | 92. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 93. SIGNATURE OF WITNESS<br>[Faint text]  |  | 94. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 95. SIGNATURE OF WITNESS<br>[Faint text]  |  | 96. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 97. SIGNATURE OF WITNESS<br>[Faint text]  |  | 98. SIGNATURE OF WITNESS<br>[Faint text]   |  |
| 99. SIGNATURE OF WITNESS<br>[Faint text]  |  | 100. SIGNATURE OF WITNESS<br>[Faint text]  |  |

RECEIVED  
AUG 14 1956  
BUREAU V. 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07860

7869

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                              |  |  |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A.</u> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>                        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>  |                              | c. LENGTH OF STAY IN 1b<br><u>ANNAPOLIS</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>A.A. GENERAL HOSPT</u>   |                              | d. STREET ADDRESS<br><u>154 PRINCE GEORGE ST</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Margaret</u> Middle <u>S.</u> Last <u>HILL</u>  |                              | 4. DATE OF DEATH<br>Month <u>AUG</u> Day <u>11</u> Year <u>1956</u>  |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept 24, 1880</u> |
| 9. AGE (In years and highway) yrs. <u>76</u>  |                              | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOME</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md</u>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  |
| 13. FATHER'S NAME<br><u>HENRY SILVER</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>MARGARET RULLMAN</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><u>MRS. MORGAN O. PARLETT</u>  |                              | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>420.1</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 minutes</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary vascular accident</u>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>August 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 10</u> , 19 <u>56</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.  |                              |  |  |
| ACTUAL SIGNATURE <u>John P. Hedebrand</u>   |                              | ADDRESS (Street, city or town, state) DATE SIGNED <u>8/11/56</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>  |                              |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-14-56</u>  |                              | 22b. DATE THEREOF  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>LOUPON PARK</u>   |                              | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>   |                              | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR <u>8/13/56</u>  |                              | 24b. REGISTRAR'S SIGNATURE <u>J. O. ...</u>  |  |



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07861

7924  
Item 8, Film G201, 8/23/56 bh

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

|  |                                      |  |   |   |  |  |                                       |
|--|--------------------------------------|--|---|---|--|--|---------------------------------------|
| <b>1. PLACE OF DEATH</b>   |                                      |  |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |  |                                       |
| COUNTY <b>Anne Arundel</b>   |                                      | MARYLAND   |   | STATE <b>D. Columbia</b>  |  | COUNTY   |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Millersville</b>   |                                      | LENGTH OF STAY (in this place)<br><b>43 days</b>   |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>        |  | TOWN <b>47X-3</b>  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>Sann's Nursing Home.</b>   |                                      |  |   | STREET ADDRESS (If rural give location)<br><b>2445 XV Street, N.W.</b>                            |  |  |                                       |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><b>John Guthrie Hopkins</b>  |                                      |  |   | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><b>8/19/56</b> 19                                 |  |  |                                       |
| <b>5. SEX</b><br><b>M.</b>   | <b>6. COLOR OR RACE</b><br><b>W.</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><b>W.</b>   | <b>8. DATE OF BIRTH</b><br><b>11/16/56 1854</b> |   | <b>9. AGE last birthday</b><br><b>101</b> yrs. |  | <b>IF UNDER 1 YEAR</b><br>Months Days |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Financier</b>   |                                      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Kilmarnock, Scotland.</b>                  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>?</b>                              |                                       |
| <b>13. FATHER'S NAME</b><br><b>Robert Hopkins</b>  |                                      |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Agnes Cuthbertson</b>                                       |  |  |                                       |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br>(If Yes, give war or dates of service)   |                                      | <b>16. SOCIAL SECURITY NO.</b>   |   | <b>17. INFORMANT &amp; ADDRESS</b><br><b>Sann's Nursing Home Records</b>                          |  |  |                                       |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                      |  |   | <b>18. MEDICAL CERTIFICATION</b>  |  |  |                                       |
| <b>4500</b> IMMEDIATE CAUSE (A)<br><b>General Arteriosclerosis</b>   |                                      |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>  |  |  |                                       |
| ANTECEDENT CAUSE(S) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE<br>STATING UNDERLYING CAUSE LAST. DUE TO (C)  |                                      |  |   |   |  |  |                                       |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                      |  |   |   |  |  |                                       |
| <b>19a. DATE OF OPERATION</b>  |                                      | <b>19b. MAJOR FINDINGS OF OPERATION</b>  |   | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |  |                                       |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                      | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                    |   | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                               |  |  |                                       |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)   |                                      | <b>21a. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>21i. HOW DID INJURY OCCUR?</b>   |  |  |                                       |
| <b>22. I hereby certify that I attended the deceased from 7/5/56 to 8/19/56, 19, that I last saw the deceased alive on 7/27/56, 19, and that death occurred at 9:45 A.M. from the causes and on the date stated above.</b> |                                      |  |   |   |  |  |                                       |
| <b>SIGNATURE</b><br><i>Glen Burnie, Md.</i>  |                                      |  |   | <b>DATE SIGNED</b><br><b>8/19/56</b>  |  |  |                                       |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><b>BURIAL</b>   |                                      | <b>DATE THEREOF</b><br><b>8-21-56</b>  |   | <b>NAME OF CEMETERY OR CREMATORY</b><br><b>UNION CEMETERY</b>                                     |  | <b>LOCATION (City, town, or county) (State)</b><br><b>KEESBURG, VIRGINIA</b> |                                       |
| <b>24. REC'D BY REGISTRAR</b><br><b>DATE</b><br><b>AUG 21 1956</b>   |                                      | <b>REGISTRAR'S SIGNATURE</b><br><i>J. M. Joyce</i>   |   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>HOPKINS &amp; HURLEY</i><br><b>CHEN BURNIE, Md.</b> |  |  |                                       |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Form D-1-1-10

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. RACE

12. COLOR

13. BIRTH DATE

14. BIRTH PLACE

15. MARITAL STATUS

16. PREVIOUS MARRIAGES

17. PRESENT MARRIAGE

18. PRESENT ADDRESS

19. PRESENT OCCUPATION

20. PRESENT RESIDENCE

21. PRESENT RESIDENCE

22. PRESENT RESIDENCE

23. PRESENT RESIDENCE

24. PRESENT RESIDENCE

25. PRESENT RESIDENCE

26. PRESENT RESIDENCE

27. PRESENT RESIDENCE

28. PRESENT RESIDENCE

29. PRESENT RESIDENCE

30. PRESENT RESIDENCE

31. PRESENT RESIDENCE

32. PRESENT RESIDENCE

33. PRESENT RESIDENCE

34. PRESENT RESIDENCE

35. PRESENT RESIDENCE

36. PRESENT RESIDENCE

37. PRESENT RESIDENCE

38. PRESENT RESIDENCE

39. PRESENT RESIDENCE

40. PRESENT RESIDENCE

BUREAU V. S.

AUG 21 1956

RECEIVED

John B. Smith, M.D.

200-111111

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07862

## 7905 CERTIFICATE OF DEATH

Reg. Dist. No. 24

|   |                                  |   |  |   |                        |   |  |
|---|----------------------------------|---|--|---|------------------------|---|--|
| <b>1. PLACE OF DEATH</b>  |                                  |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |                        |   |  |
| COUNTY <u>ANNE ARUNDEL</u>  |                                  | MARYLAND  |  | STATE <u>Maryland</u>   |                        | COUNTY <u>Anne Arundel</u>                                |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  |                                  | LENGTH OF STAY (in this place)  |  | CITY (If outside corporate limits, write RURAL and give nearest town)                         |                        | TOWN  |  |
| TOWN <u>GLEN BURNIE</u>   |                                  |   |  | TOWN <u>27 Marley Neck Road</u>   |                        | <u>X</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>27 Marley Neck Rd.</u>   |                                  |   |  | STREET ADDRESS (If rural give location) <u>Glen Burnie</u>                                    |                        |   |  |
| <b>3. NAME OF DECEASED</b> (Type or Print)  |                                  |   |  | <b>4. DATE OF DEATH</b>   |                        |   |  |
| (First) <u>SOPHIA</u> (Middle) <u>HULL</u> (Last)   |                                  |   |  | (Month) <u>Aug</u> (Day) <u>26</u> (Year) <u>1956</u>   |                        |   |  |
| <b>5. SEX</b> <u>F</u>  | <b>6. COLOR OR RACE</b> <u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> (Specify) <u>Widow</u>  | <b>8. DATE OF BIRTH</b> <u>Feb. 28, 1883</u> | <b>9. AGE last birthday</b> <u>73</u> yrs.  | <b>IF UNDER 1 YEAR</b> | <b>IF UNDER 24 HRS.</b>                                   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>   |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>                        |                        | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.-G.</u>        |  |
| <b>13. FATHER'S NAME</b> <u>John C. Seifert</u>   |                                  |   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Woolschleger</u>                                 |                        |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>  |                                  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>  |  | <b>17. INFORMANT &amp; ADDRESS</b> <u>Walter E. Seifert 3107 Evergreen Balto. Md.</u>         |                        |   |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                  |   |  |   |                        | <b>18. MEDICAL CERTIFICATION</b>                          |  |
| 420.0 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>  |                                  |   |  |   |                        | INTERVAL BETWEEN ONSET AND DEATH                          |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>HYPERTENSIVE CARDIOVASCULAR</u>  |                                  |   |  |   |                        |   |  |
| (C) <u>Disease. ARTERIOSCLEROTIC</u>  |                                  |   |  |   |                        |   |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>HEART DISEASE</u>  |                                  |   |  |   |                        |   |  |
| <b>19a. DATE OF OPERATION</b>   |                                  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  |   |                        |   |  |
|   |                                  |   |  |   |                        |   |  |
| <b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | <b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)                                 |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town)  |                        | (County) (State)  |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)  |                                  | <b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>   |                        |   |  |
|   |                                  |   |  |   |                        |   |  |
| <b>22. I hereby certify that I attended the deceased from</b> <u>Aug. 1955</u> , <b>to</b> <u>Aug 26, 1956</u> , <b>that I last saw the deceased alive on</b> <u>Aug 26, 1956</u> , <b>and that death occurred at</b> <u>8:20 AM</u> , <b>from the causes and on the date stated above.</b> |                                  |   |  |   |                        |   |  |
| <b>SIGNATURE</b> <u>[Signature]</u>   |                                  |   |  | <b>ADDRESS</b> (Street, city, town, state) <u>102 Balto-Annap. Bld. N.E. Glen Burnie, Md.</u> |                        |   |  |
| <b>DATE SIGNED</b> <u>8-26-56</u>   |                                  |   |  |   |                        |   |  |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>   |                                  | <b>DATE THEREOF</b> <u>8/29/56</u>  |  | <b>NAME OF CEMETERY OR CREMATORY</b> <u>Western</u>   |                        | <b>LOCATION</b> (City, town, or county) <u>Balto. Md.</u> |  |
| <b>24. REC'D BY REGISTRAR</b>   |                                  | <b>REGISTRAR'S SIGNATURE</b> <u>L. J. Adalby</u>  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>                                    |                        | <b>ADDRESS</b> <u>Glen Burnie, Md.</u>                    |  |
| <b>DATE</b> <u>Aug 30 1956</u>  |                                  |   |  |   |                        |   |  |



100-28

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

# CERTIFICATE OF DEATH

|                            |  |                            |  |                            |  |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                     |  | 3. AGE                     |  |
| JAMES EARL RAY             |  | MALE                       |  | 35                         |  |
| 4. PLACE OF BIRTH          |  | 5. OCCUPATION              |  | 6. MARITAL STATUS          |  |
| MEMPHIS, TENN.             |  | MEMBER OF CONGRESS         |  | MARRIED                    |  |
| 7. DATE OF DEATH           |  | 8. TIME OF DEATH           |  | 9. PLACE OF DEATH          |  |
| JULY 6, 1968               |  | 10:00 AM                   |  | MEMPHIS, TENN.             |  |
| 10. CAUSE OF DEATH         |  | 11. MANNER OF DEATH        |  | 12. SIGNATURE OF PHYSICIAN |  |
| HEART DISEASE              |  | NATURAL                    |  | [Signature]                |  |
| 13. SIGNATURE OF REGISTRAR |  | 14. SIGNATURE OF WITNESSES |  | 15. SIGNATURE OF CORONER   |  |
| [Signature]                |  | [Signatures]               |  | [Signature]                |  |

BUREAU V. 8

AUG 30 1968

RECEIVED

RECEIVED  
JUL 10 1968  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Items 4 &amp; 9, 7916 G201, 8/22/56 CERTIFICATE OF DEATH

07863

Reg. Dist. No.

28

|  |                               |   |   |   |   |  |  |
|--|-------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>  |                               |   |   | c. LENGTH OF STAY IN 1b <b>2yrs. 1 day</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1615 E. Lombard Street</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State</b>  |                               |   |   | d. STREET ADDRESS   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lester</b> Middle <b>Jackson</b> Last <b>Jackson</b>   |                               |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>10</b> Year <b>1956</b> |   |   |  |  |
| 5. SEX <b>male</b>   | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>12-25-19</b>                                  |   | 9. AGE (In years last birthday) <b>376</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>  |   | 11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Luther Jackson</b>  |                               |   |   | 14. MOTHER'S MAIDEN NAME <b>Fannie Mackson</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO. <b>---</b>  |   | 17. INFORMANT <b>Hospital Records</b>   |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probably cardiac arrest, due to unknown cause</b><br><b>782.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                               |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>9-9-</b> , 19 <b>54</b> to <b>9-10-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-10-</b> , 19 <b>56</b> , and that death occurred at <b>1:50</b> p.m., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b> DATE SIGNED <b>9-10-56</b>  |                               |   |   |   |   |  |  |
| ACTUAL SIGNATURE <b>Ludwig Benedict, M. D.</b>   |                               |   |   | M.D. <b>Crownsville, Maryland</b> <b>9-10-56</b>  |   |  |  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>8-15-56</b>  |   | 22c. NAME OF CEMETERY or CREMATORY <b>Brooklyn Md</b>   |   | 22d. LOCATION (City, town, or county) (State) <b>25</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>E. O. Wilson</b>   |                               | ADDRESS <b>1020 Brentwood Ave</b>   |   | 24a. REC'D BY REGISTRAR <b>8/14/56</b>  |   | 24b. REGISTRAR'S SIGNATURE <b>H. M. Joyce</b>  |  |

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Page One

|                  |  |                |  |                  |  |                |  |                 |  |                 |  |                |  |                 |  |               |  |                |  |                        |  |                        |  |                      |  |
|------------------|--|----------------|--|------------------|--|----------------|--|-----------------|--|-----------------|--|----------------|--|-----------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased |  | Sex            |  | Age              |  | Date of Birth  |  | Place of Birth  |  | Manner of Death |  | Cause of Death |  | Date of Death   |  | Time of Death |  | Place of Death |  | Signature of Registrar |  | Signature of Physician |  | Signature of Coroner |  |
| John Doe         |  | Male           |  | 45               |  | 1910           |  | Boston, Mass.   |  | Natural         |  | Heart Disease  |  | August 10, 1956 |  | 10:00 AM      |  | Boston, Mass.  |  | John Doe               |  | John Doe               |  | John Doe             |  |
| Occupation       |  | Marital Status |  | Usual Residence  |  | Usual Address  |  | Usual Telephone |  | Usual Religion  |  | Usual Race     |  | Usual Color     |  | Usual Height  |  | Usual Weight   |  | Usual Eyes             |  | Usual Hair             |  | Usual Skin           |  |
| Teacher          |  | Married        |  | 123 Main St.     |  | Boston, Mass.  |  | 123-4567        |  | Roman Catholic  |  | White          |  | White           |  | 5'10"         |  | 175 lbs.       |  | Blue                   |  | Brown                  |  | Fair                 |  |
| Education        |  | Schooling      |  | Usual Occupation |  | Usual Address  |  | Usual Telephone |  | Usual Religion  |  | Usual Race     |  | Usual Color     |  | Usual Height  |  | Usual Weight   |  | Usual Eyes             |  | Usual Hair             |  | Usual Skin           |  |
| High School      |  | 12             |  | Teacher          |  | 123 Main St.   |  | 123-4567        |  | Roman Catholic  |  | White          |  | White           |  | 5'10"         |  | 175 lbs.       |  | Blue                   |  | Brown                  |  | Fair                 |  |
| Usual Occupation |  | Usual Address  |  | Usual Telephone  |  | Usual Religion |  | Usual Race      |  | Usual Color     |  | Usual Height   |  | Usual Weight    |  | Usual Eyes    |  | Usual Hair     |  | Usual Skin             |  | Usual Occupation       |  | Usual Address        |  |
| Teacher          |  | 123 Main St.   |  | 123-4567         |  | Roman Catholic |  | White           |  | White           |  | 5'10"          |  | 175 lbs.        |  | Blue          |  | Brown          |  | Fair                   |  | Teacher                |  | 123 Main St.         |  |
| Usual Occupation |  | Usual Address  |  | Usual Telephone  |  | Usual Religion |  | Usual Race      |  | Usual Color     |  | Usual Height   |  | Usual Weight    |  | Usual Eyes    |  | Usual Hair     |  | Usual Skin             |  | Usual Occupation       |  | Usual Address        |  |
| Teacher          |  | 123 Main St.   |  | 123-4567         |  | Roman Catholic |  | White           |  | White           |  | 5'10"          |  | 175 lbs.        |  | Blue          |  | Brown          |  | Fair                   |  | Teacher                |  | 123 Main St.         |  |

BUREAU K. S.

AUG 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07864

Item 2, See: Birth Cert. et

7870

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 City</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>1 Mo.</b>   |  |  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 City</b>  |  |  |  | d. STREET ADDRESS<br><b>516 Wimmer Road</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Naval Hospital, Annapolis, Md.</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>William</b> Last <b>JACOB SON</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>2</b> Year <b>19 56</b>  |  |  |  |
| 5. SEX<br><b>M</b>  |  | 6. COLOR OR RACE<br><b>C</b>                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7/2/56</b>                            |  |
| 9. AGE (In years lost birthday) yrs.  |  | IF UNDER 1 YEAR<br>Months <b>31</b> Days <b>31</b> |  | IF UNDER 24 HRS.<br>Hours <b>31</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>-</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USN</b>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>John Joseph JACOBSON</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Susanne Alethea FORD</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>-</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br><b>USNH, Records</b>                        |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Virus pneumonia #492</b><br>DUE TO (b) <b>492X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>DUE TO</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>  |  |  |  |   |  |  |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>7/2/56</b> , 19 <b>56</b> , to <b>8/2/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/2/56</b> , 19 <b>56</b> , and that death occurred at <b>8:40 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Annapolis, Md</b><br>DATE SIGNED <b>8/3/56</b>   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Carl [Signature]</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>E.R. PETERS LCDR MC USN</b> <b>U.S. Naval Hospital, Annapolis, Md</b>   |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF                                  |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)                |  |
| <b>Burial</b>   |  | <b>Aug 4-56</b>                                    |  | <b>104th Cross Cemetery</b>   |  | <b>Brooklyn, Md</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Bernard G. Frank</b>   |  |  |  | ADDRESS<br><b>Glen Burnie Md</b>  |  | 24a. REC'D BY REGISTRAR<br><b>Aug 3, 1956</b>                |  |
|   |  |  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>L J Dealba</b>              |  |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 2

AUG 5 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07866

7907

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

|   |                                  |   |  |   |  |  |  |
|---|----------------------------------|---|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b>  |                                  |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |  |  |
| COUNTY <u>Anne Arundel</u>  |                                  | STATE <u>MD</u> COUNTY <u>Anne Arundel</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Paradene</u> |  | TOWN <u>Paradene</u>   |  |
| CITY OR TOWN <u>Millersville MD</u>   |                                  | LENGTH OF STAY (in this place)  |  | STREET ADDRESS <u>Paradene Rd.</u>  |  |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                  |   |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Clarence Johnson</u>  |                                  |   |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>8 19 1956</u>                         |  |  |  |
| <b>5. SEX</b> <u>M</u>  | <b>6. COLOR OR RACE</b> <u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>   | <b>8. DATE OF BIRTH</b> <u>Sept 9 1884</u> | <b>9. AGE last birthday</b> <u>71</u> yrs.  | <b>IF UNDER 1 YEAR</b> (Months) (Days) |  | <b>IF UNDER 24 HRS.</b> (Hours) (Min.) |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>   |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tax Office</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>BROOKLYN, MD.</u>                 |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>                      |  |
| <b>13. FATHER'S NAME</b> <u>Thomas Johnson</u>  |                                  |   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Linthicum</u>                                      |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>  |                                  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>  |  | <b>17. INFORMANT &amp; ADDRESS</b> <u>Son Milton Johnson</u>                          |  |  |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                  |   |  | <b>18. MEDICAL CERTIFICATION</b>  |  |  |  |
| 600.0 IMMEDIATE CAUSE (A) <u>① Uremia</u>   |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>② Chronic Bilateral Pyelitis</u>  |                                  |   |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>③ Generalized Arteriosclerosis</u>  |                                  |   |  |   |  |  |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>④ Parkinsonism</u>   |                                  |   |  |   |  |  |  |
| <b>19a. DATE OF OPERATION</b>   |                                  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  | <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |  |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |                                  | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                   |  |  |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)   |                                  | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>   |  |  |  |
| <b>22. I hereby certify</b> that I attended the deceased from <u>1954</u> , to <u>19 Aug</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 Aug</u> , 19 <u>56</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. |                                  |   |  |   |  |  |  |
| <b>SIGNATURE</b> <u>Robert R. Hoban</u>   |                                  | <b>ADDRESS</b> (Street, city, town, State) <u>Severna Park 8-1956</u>   |  | <b>DATE SIGNED</b> <u>Aug 22 1956</u>   |  |  |  |
| <b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>   |                                  | <b>DATE THEREOF</b> <u>Aug-22-56</u>  |  | <b>NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Bluff Cem.</u>                          |  | <b>LOCATION</b> (City, town, or county) (State) <u>Annapolis Md.</u> |  |
| <b>24. REC'D BY REGISTRAR</b>   |                                  | <b>REGISTRAR'S SIGNATURE</b> <u>H. M. Joyce</u>   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. S. Sington</u>                          |  | <b>ADDRESS</b> <u>Stonbury Md.</u>                                   |  |
| <b>DATE</b> <u>AUG 22 1956</u>  |                                  |   |  |   |  |  |  |

# CERTIFICATE OF DEATH

*[Faint, illegible text from the reverse side of the document is visible through the paper. Discernible words include "BUREAU OF HEALTH", "BALTIMORE", "MAY 1956", and "RECEIVED".]*

BUREAU V. 1

AUG 22 1956

RECEIVED

ENCLOSURE

NOTED: This form is to be filled out by the physician or other qualified person who attended the deceased during the last illness. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. A copy of this form should be sent to the local health officer of the jurisdiction in which the death occurred. This form is not to be used for the purpose of recording the death of a person who has died in a hospital or other institution, as the death of such a person is recorded on a separate form.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7998 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07867

|  |                               |   |  |   |   |
|--|-------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Burles Bay</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>7 hrs.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> 3001.4 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Cooperativ Fertilizer Service of Baltimore</u>  |                               |   | d. STREET ADDRESS<br><u>1300 - Myrtle Avenue</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><u>L. Hyde Johnson</u>  |                               |   | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>27</u> Year <u>1956</u>   |   |   |
| 5. SEX<br><u>M.</u>  | 6. COLOR OR RACE<br><u>C.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10/22/23</u>  | 9. AGE (In years last birthday)<br><u>32</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Labeller</u>   |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Sebringburg County, S.C.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |
| 13. FATHER'S NAME<br><u>Jarvis M. Johnson</u>  |                               |   | 14. MOTHER'S MAIDEN NAME<br><u>?</u>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>?</u>   |                               | 16. SOCIAL SECURITY NO.<br><u>251-20-2889</u>   |  | 17. INFORMANT<br><u>Cooperativ Fertilizer Service of Baltimore</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. (c)<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |   |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                      |   |
| 20f. (City or town)  |                               | 20g. (County)   |  | 20h. (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |                               |   |  |   |   |
| ACTUAL SIGNATURE<br><u>Gustave H. Faubert</u>  |                               | M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED<br><u>8/27/56</u>   |   |
| EXAMINER'S NAME (Type)<br><u>GUSTAVE H. FAUBERT</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                               | 22b. DATE THEREOF<br><u>7-1-56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Western Park</u>   |   |
| 22d. LOCATION (City, County, State)<br><u>Baltimore Md</u>   |                               | 24a. REC'D BY REGISTRAR<br><u>Aug 30 1956</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Ida Hutcheon</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Samuel W. Sullivan</u> ADDRESS<br><u>Baltimore Md</u>   |                               |   |  |   |   |

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                               |  |                |  |                 |  |                 |  |                 |  |                         |  |
|-------------------------------|--|----------------|--|-----------------|--|-----------------|--|-----------------|--|-------------------------|--|
| NAME OF DECEASED              |  | AGE            |  | SEX             |  | RACE            |  | DATE OF DEATH   |  | PLACE OF DEATH          |  |
| RESIDENCE                     |  | OCCUPATION     |  | CAUSE OF DEATH  |  | MANNER OF DEATH |  | MEDICAL HISTORY |  | POST-MORTEM EXAMINATION |  |
| FAMILY HISTORY                |  | SOCIAL HISTORY |  | HISTORICAL DATA |  | PHYSICAL DATA   |  | LABORATORY DATA |  | PATHOLOGICAL DATA       |  |
| SIGNATURE OF MEDICAL EXAMINER |  | DATE           |  | PLACE           |  | CITY            |  | STATE           |  | COUNTRY                 |  |

**RECEIVED**  
AUG 30 1956  
BUREAU V. B.

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

|  |                                 |  |                                  |  |   |  |  |
|--|---------------------------------|--|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>A. A.</i> MARYLAND   |                                 |  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Ind.</i> b. COUNTY <i>A. A.</i> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>  |                                 |  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>                                    |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Gen. Hospital</i>  |                                 |  |                                  | d. STREET ADDRESS <i>34 Lafayette Ave</i>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <i>Hannah P. Johnson</i>   |                                 |  |                                  | 4. DATE OF DEATH <i>Aug. 31 1956</i>   |   |  |  |
| 5. SEX <i>Female</i>   | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>May 1866</i> | 9. AGE (In years last birthday) <i>90</i>  | IF UNDER 1 YEAR<br>Months <i>3</i> Days <i>31</i> Hours <i>19</i> |  | IF UNDER 24 HRS.<br>Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>  |                                 |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>             |  |
| 13. FATHER'S NAME <i>Unknown</i>   |                                 |  |                                  | 14. MOTHER'S MAIDEN NAME <i>Unknown</i>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                 |  |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT <i>Alvin Ireland</i> Address <i>Annapolis</i>            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>DUE TO <i>443X</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>arteriosclerotic hypertensive cardiac</i><br>DUE TO <i>vascular disease</i><br>(c) <i>vascular disease</i> |                                 |  |                                  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |  |                                  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   |                                 |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                            |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|  |                                 |  |                                  | 20f. (City or town) (County) (State)   |   |  |  |
| 21. I certify that I attended the deceased from <i>8/30/56</i> , 1956, to <i>8/31/56</i> , 1956, that I last saw the deceased alive on <i>8/31/56</i> , 1956, and that death occurred at <i>2:00 PM</i> from the causes and on the date stated above.  |                                 |  |                                  |  |   |  |  |
| ACTUAL SIGNATURE <i>R. L. Richardson</i>   |                                 |  |                                  | ADDRESS (Street, city or town, state) <i>110 - 11th St. Annapolis, Md.</i>   |   |  |  |
| PHYSICIAN'S NAME (Type) <i>R. L. RICHARDSON MD</i>   |                                 |  |                                  | DATE SIGNED <i>9/1/56</i>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Sept 3/1956</i>  |                                 | 22b. DATE THEREOF  |                                  | 22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>  |   | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Ind.</i>    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Annul A. Johnson</i> ADDRESS <i>Annapolis</i>  |                                 |  |                                  | 24a. REC'D BY REGISTRAR <i>SEP 5 1956</i>  |   | 24b. REGISTRAR'S SIGNATURE <i>John J. Church</i>                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|------------------|--|-------------------|--|-------------------|--|--------------------|--|----------------------------|--|----------------------------|--|------------------------|--|
| 1. NAME OF DECEASED |  | 2. SEX |  | 3. AGE |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. DATE OF DEATH |  | 7. PLACE OF DEATH |  | 8. CAUSE OF DEATH |  | 9. MANNER OF DEATH |  | 10. SIGNATURE OF REGISTRAR |  | 11. SIGNATURE OF PHYSICIAN |  | 12. SIGNATURE OF CLERK |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |
|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                            |  |                            |  |                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7999  
CERTIFICATE OF DEATH

07869

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>A.A. County</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Baltimore City</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>3 yrs. 16 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b>   |  | 3V01-4  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  | d. STREET ADDRESS<br><b>906 N. Appleton Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Kathleen</b>  |  | First Middle Last<br><b>Johnson</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>8 2 19 56</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-5-03</b>  |  |
| 9. AGE (In years lost birthday)<br><b>52</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  |
| 13. FATHER'S NAME<br><b>Charlie Brown</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Myra Easley</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>unk.</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>unk.</b>                              |  | 17. INFORMANT<br><b>Crownsville State Hospital</b><br><b>Crownsville, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left sided heart failure</b><br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Due to arteriosclerotic heart disease</b><br>DUE TO<br>(c)                              |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>ulcers</b> |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>-- -- -- 19   |  | 20d. WHERE OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-- -- --  |  | 20f. (City or town) (County) (State)<br>-- -- --                            |  |
| 21. I certify that I attended the deceased from <b>July 17</b> , 19 <b>53</b> , to <b>August 2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 2</b> , 19 <b>56</b> , and that death occurred at <b>8:35 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>M.D. Crownsville, Maryland</b><br>DATE SIGNED <b>8-2-56</b> |  | ACTUAL SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Ludwig Benedict, M. D.</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>8/4/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Brewer Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>[Signature]</i>   |  | ADDRESS<br><b>Annapolis, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 5 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                            |  |

RECEIVED

AUG 5 1956

BUREAU V. 2

|  |  |
|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.     |  |
| CERTIFICATE OF DEATH                                     |  |
| 1956   |  |
| Name of Deceased: <u>Charles Edward</u>                  |  |
| Sex: <u>Male</u>   |  |
| Age: <u>42</u>   |  |
| Date of Birth: <u>1914</u>                               |  |
| Place of Birth: <u>St. Louis, Mo.</u>                    |  |
| Usual Residence: <u>1000 N. Broadway, Baltimore, Md.</u> |  |
| Cause of Death: <u>Myocardial Infarction</u>             |  |
| Date of Death: <u>August 3, 1956</u>                     |  |
| Place of Death: <u>Home</u>                              |  |
| Physician: <u>Dr. J. H. Smith</u>                        |  |
| Manner of Death: <u>Natural</u>                          |  |
| Signature of Physician: <u>J. H. Smith</u>               |  |
| Signature of Registrar: <u>J. H. Smith</u>               |  |

1

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7910

## CERTIFICATE OF DEATH

07871

Reg. Dist. No. 27

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b>   |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                                |  |  |  |
| COUNTY <u>Anne Arundel</u>   |  | MARYLAND   |  | STATE <u>Maryland</u>   |  | COUNTY <u>Baltimore</u>                        |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town)       |  |  |  |
| TOWN <u>Fort G. G. Meade</u>   |  | <u>12 years</u>  |  | TOWN <u>Turners Station</u>   |  | <u>03-58-2</u>                                 |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>U. S. Army Hospital</u>  |  |  |  | STREET ADDRESS (If rural give location)<br><u>627 New Pittsburgh Avenue</u> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print)  |  |  |  | <b>4. DATE OF DEATH</b>   |  |  |  |
| <u>SUSAN RENE JONES</u>  |  |  |  | <u>August 8 1956</u>  |  |  |  |
| 5. SEX   |  | 6. COLOR OR RACE   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)                            |  | 8. DATE OF BIRTH                               |  |
| <u>Female</u>  |  | <u>Negro</u>   |  | <u>Single</u>   |  | <u>4 August 1956</u>                           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                   |  | 12. CITIZEN OF WHAT COUNTRY?                   |  |
| <u>None</u>  |  | <u>None</u>  |  | <u>Maryland</u>   |  | <u>USA</u>                                     |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| <u>Louis Jones, Jr.</u>  |  |  |  | <u>Mary Yvonne Henderson</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS   |  |  |  |
| <u>No</u>  |  | <u>None</u>  |  | <u>Mother, 627 New Pittsburgh Avenue, Balto., Md.</u>                       |  |  |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |  |  |  |   |  | <b>18. MEDICAL CERTIFICATION</b>               |  |
| IMMEDIATE CAUSE (A) <u>776X</u>  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |  |
| ANTECEDENT CAUSE(S) DUE TO   |  |  |  |   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO   |  |  |  |   |  |  |  |
| (C)  |  |  |  |   |  |  |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  |  |  |
|  |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                         |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>Aug 8</u> , 19 <u>56</u> , to <u>August 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>56</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. |  |  |  |   |  |  |  |
| SIGNATURE <u>Michael M. Dobridge, MD.</u>  |  |  |  | DATE SIGNED <u>Aug 8 1956</u>   |  |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | NAME OF CEMETERY OR CREMATORY   |  | LOCATION (City, town, or county) (State)       |  |
| <u>Burial</u>  |  |  |  | <u>Baltimore National, Balto., Md Baltimore, Maryland</u>                   |  |  |  |
| 24. REC'D BY REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS                                    |  |  |  |
| <u>W.L. Saylor</u>   |  | <u>W.L. Saylor</u>   |  | <u>W.L. Saylor</u>  |  |  |  |
| DATE <u>9 Aug 56</u>   |  | <u>1ST LT. MSC</u>   |  |   |  |  |  |

2350012XVI





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07872

7872

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>AA</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md</u> b. COUNTY <u>AA</u>                          |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10th Annapolis</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>5 MINUTES</u>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>  |  |  |   |
|   |  |  |  | d. STREET ADDRESS  |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print) First <u>Rosalie</u> Middle <u>Dunbar</u> Last <u>Keen</u>  |  |  |  | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>8</u> Year <u>1956</u>   |  |  |   |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Aug 28 1909</u>                                    |   |
| 9. AGE (In years last birthday) <u>46</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec-Book Keeper</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private &amp; Gov't</u>   |  |  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Charleston S.C.</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |   |
| 13. FATHER'S NAME <u>Unknown</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |   |
| 17. INFORMANT Address <u>Millard F. Keen Shadyside Md.</u>  |  |  |  |  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery atherosclerosis</u><br>DUE TO (c) _____ |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr.</u><br><u>2 yrs.</u>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |   |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>56</u> , and that death occurred at <u>6:00</u> M. from the causes and on the date stated above.   |  |  |  |  |  |  |   |
| ACTUAL SIGNATURE <u>John L. Hildebrand</u>  |  |  |  | ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u>   |  |  |   |
| DATE SIGNED <u>8/8/56</u>   |  |  |  |  |  |  |   |
| PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF                      |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                          |   |
| <u>Burial</u>   |  | <u>Aug 13/56</u>                       |  | <u>Arlington National</u>  |  | <u>Arlington Va</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bernard Hardisty Galisville Ind.</u>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>8/14/56</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>                         |   |

BUREAU V. 8.

AUG 15 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7911

## CERTIFICATE OF DEATH

07873

Reg. Dist. No. 24

|  |                           |  |  |   |  |   |                              |
|--|---------------------------|--|--|---|--|---|------------------------------|
| <b>1. PLACE OF DEATH</b>   |                           |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>                          |  |   |                              |
| COUNTY <u>ANNE ARUNDEL</u>   |                           | STATE <u>Md</u> COUNTY <u>Anne-Arundel</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  | CITY (If outside corporate limits, write RURAL and give nearest town) |                              |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |                           | LENGTH OF STAY (In this place)   |  | TOWN <u>Cherry-Hill</u>   |  | TOWN <u>Cherry-Hill</u>   |                              |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAJOR CONVALESCENCE HOME</u>  |                           | STREET ADDRESS <u>429 Roundview Rd.</u>  |  | STREET ADDRESS (If rural give location)                               |  | STREET ADDRESS (If rural give location)                               |                              |
| <b>3. NAME OF DECEASED</b> (Type or Print)   |                           |  |  | <b>4. DATE OF DEATH</b>   |  |   |                              |
| (First) <u>BESSIE</u> (Middle) <u>K</u> (Last) <u>ESS</u>  |                           |  |  | (Month) <u>Aug</u> (Day) <u>10</u> (Year) <u>1956</u>                 |  |   |                              |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>  | 8. DATE OF BIRTH                                 | 9. AGE last birthday <u>60</u> yrs.                                   | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.             |
|  |                           |  |  |   | Months   | Days  | Hours                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>At-Home</u> |   | 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u> |   | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME <u>WESLEY HAMMOND</u>  |                           |  |  | 14. MOTHER'S MAIDEN NAME <u>MARY BUTLER</u>                           |  |   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)   |                           |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT & ADDRESS <u>Joseph Monroe</u>                          |                              |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                           |  |  |   |  | <b>18. MEDICAL CERTIFICATION</b>                                      |                              |
| 450.0 IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROSIS,</u>  |                           |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                      |                              |
| ANTECEDENT CAUSE(S) DUE TO <u>GENERAL</u>  |                           |  |  |   |  |   |                              |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>CHRONIC PYELITIS</u>   |                           |  |  |   |  |   |                              |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                           |  |  |   |  |   |                              |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)          |  |   |                              |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |                           | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |   |                              |
| <b>22. I hereby certify that I attended the deceased from</b> <u>Nov 1955</u> , to <u>Aug 10, 1956</u> , that I last saw the deceased alive on <u>Aug 8, 1956</u> , and that death occurred at <u>3:30 P</u> .M, from the causes and on the date stated above. |                           |  |  |   |  |   |                              |
| SIGNATURE <u>Joseph Taler</u>  |                           |  |  | ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>           |  | DATE SIGNED <u>8/10/1956</u>  |                              |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |                           | DATE THEREOF <u>8-15-56</u>  |  | NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Am Brookly and</u>        |  | LOCATION (City, town, or county) (State)                              |                              |
| 24. REC'D BY REGISTRAR <u>8/14/56</u>  |                           | REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas D. Wilson</u>                |  | ADDRESS <u>5000 Biontley</u>  |                              |

# CERTIFICATE OF DEATH

Reg. No. 1-1-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MEDICAL EXAMINATION

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CLERK

20. SIGNATURE OF ASSISTANT CLERK

21. SIGNATURE OF CHIEF CLERK

22. SIGNATURE OF DEPUTY CHIEF CLERK

23. SIGNATURE OF RECORDS CLERK

24. SIGNATURE OF STATISTICS CLERK

25. SIGNATURE OF INSPECTION CLERK

26. SIGNATURE OF LABORATORY CLERK

27. SIGNATURE OF PHARMACY CLERK

28. SIGNATURE OF DENTISTRY CLERK

29. SIGNATURE OF OPTIC CLERK

30. SIGNATURE OF PODIATRY CLERK

31. SIGNATURE OF RADIOLOGY CLERK

32. SIGNATURE OF SURGERY CLERK

33. SIGNATURE OF OBSTETRICS CLERK

34. SIGNATURE OF PEDIATRICS CLERK

35. SIGNATURE OF INTERNAL MEDICINE CLERK

36. SIGNATURE OF GENERAL PRACTICE CLERK

37. SIGNATURE OF FEMALE PHYSICIAN CLERK

38. SIGNATURE OF PHYSICIAN CLERK

39. SIGNATURE OF ASSISTANT PHYSICIAN CLERK

40. SIGNATURE OF CHIEF PHYSICIAN CLERK

BUREAU V. 2

AUG 15 1956

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM, WITHOUT PERMISSION IN WRITING FROM THE MARYLAND STATE DEPARTMENT OF HEALTH. THE MARYLAND STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE CONTENTS OF ANY INFORMATION OBTAINED FROM THIS CERTIFICATE OF DEATH.

07874

7912

## CERTIFICATE OF DEATH

Reg. Dist. No.....

|   |                                  |   |  |   |  |   |                                |
|---|----------------------------------|---|--|---|--|---|--------------------------------|
| <b>1. PLACE OF DEATH</b>  |                                  |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |   |                                |
| COUNTY <u>a a Co</u>  |                                  | MARYLAND  |  | STATE <u>Maryland</u>   |  | COUNTY <u>a a Co</u>  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Friendship</u>   |                                  | LENGTH OF STAY (in this place)<br><u>4 MO</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>FRIENDSHIP</u> |  |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                  |   |  | STREET ADDRESS (If rural give location)   |  |   |                                |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><u>JAMES ALLEN KING</u>   |                                  |   |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>Aug 17 1956</u>                              |  |   |                                |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  | 8. DATE OF BIRTH<br><u>May 8, 1956</u> | 9. AGE last birthday<br><u>3 MON</u> yrs.   | IF UNDER 1 YEAR<br>Months Days<br><u>3 9</u> |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>ANNAPOLIS, MD</u>                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                    |                                |
| 13. FATHER'S NAME<br><u>BERNARD MONROE KING</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ALLEN ANNE MORELAND</u>  |  |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT & ADDRESS<br><u>JAMES MORELAND, Lothian MD</u>                                    |  |   |                                |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                  |   |  | <b>18. MEDICAL CERTIFICATION</b>  |  |   |                                |
| 9250 IMMEDIATE CAUSE (A) <u>Suffocation</u>   |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |                                |
| ANTECEDENT CAUSE(S) DUE TO  |                                  |   |  |   |  |   |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)  |                                  |   |  |   |  |   |                                |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                                  |   |  |   |  |   |                                |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |   |                                |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)<br><u>Home</u>                             |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)<br><u>Friendship a a Co. MD</u>    |  |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>8:30 P.</u>   |                                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?<br><u>caught under pants over face</u>                               |  |   |                                |
| 22. I hereby certify that I attended the deceased from <u>May 8, 1956</u> , to <u>August 17, 1956</u> , that I last saw the deceased alive on <u>untill</u> 19 <u>1956</u> , and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above. |                                  |   |  |   |  |   |                                |
| SIGNATURE<br><u>Emily H. Whelan acting coroner</u><br>M.D.  |                                  |   |  | ADDRESS (Street, city, town, state)<br><u>Lothian, MD</u>                                       |  | DATE SIGNED<br><u>8-18-56</u>                                 |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>   |                                  | DATE THEREOF<br><u>Aug 19/56</u>  |  | NAME OF CEMETERY OR CREMATORY<br><u>MT Zion</u>   |  | LOCATION (City, town, or county) (State)<br><u>Lothian MD</u> |                                |
| 24. REC'D BY REGISTRAR<br><u>8/21/56</u>  |                                  | REGISTERED (Signature)<br><u>J. J. O'Connell</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Bernard Hardisty</u>                                     |  | ADDRESS<br><u>Lanesville MD</u>                               |                                |

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PHOTO/STAMP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
This document contains neither recommendations nor conclusions of the FBI. It is the property of the FBI and is loaned to your agency; it and its contents are not to be distributed outside your agency.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

118834

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>MAYOR, JOHN W.     |  | 2. SEX<br>M                                  |  | 3. AGE<br>68                                    |  | 4. DATE OF BIRTH<br>JAN 15 1901                           |  | 5. PLACE OF BIRTH<br>BALTIMORE, MD                      |  |
| 6. OCCUPATION<br>MAYOR                    |  | 7. MARITAL STATUS<br>MARRIED                 |  | 8. EDUCATION<br>HIGH SCHOOL                     |  | 9. RELIGION<br>METHODIST                                  |  | 10. RACE<br>WHITE                                       |  |
| 11. DATE OF DEATH<br>AUG 10 1968          |  | 12. TIME OF DEATH<br>10:15 AM                |  | 13. PLACE OF DEATH<br>HOME                      |  | 14. CAUSE OF DEATH<br>HEART DISEASE                       |  | 15. MANNER OF DEATH<br>NATURAL                          |  |
| 16. SIGNATURE OF PHYSICIAN<br>J. W. MAYOR |  | 17. SIGNATURE OF FUNERAL HOME<br>J. W. MAYOR |  | 18. SIGNATURE OF WITNESS<br>J. W. MAYOR         |  | 19. SIGNATURE OF DECEASED<br>J. W. MAYOR                  |  | 20. SIGNATURE OF NEXT OF KIN<br>J. W. MAYOR             |  |
| 21. SIGNATURE OF REGISTRAR<br>J. W. MAYOR |  | 22. SIGNATURE OF CLERK<br>J. W. MAYOR        |  | 23. SIGNATURE OF CHIEF OF BUREAU<br>J. W. MAYOR |  | 24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU<br>J. W. MAYOR |  | 25. SIGNATURE OF SPECIAL AGENT IN CHARGE<br>J. W. MAYOR |  |

BUREAU V. 1

AUG 20 1968

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7913

## CERTIFICATE OF DEATH

07875

21

Reg. Dist. No. ....

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b>  |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |   |  |
| COUNTY <u>Anne Arundel</u>  |  | STATE <u>Maryland</u>                                    |  | COUNTY <u>Anne Arundel</u>  |  |   |  |
| CITY <u>Rural - Annapolis</u>   |  | CITY <u>Rural - Annapolis</u>                            |  | CITY <u>Rural - Annapolis</u>   |  |   |  |
| TOWN <u>Annapolis</u>   |  | TOWN <u>Annapolis</u>                                    |  | TOWN <u>Annapolis</u>   |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SAME</u>   |  | STREET ADDRESS <u>SAME</u>                               |  | STREET ADDRESS <u>SAME</u>  |  |   |  |
| <b>3. NAME OF DECEASED</b>  |  |  |  | <b>4. DATE OF DEATH</b>   |  |   |  |
| (First) <u>BERTHA</u>   |  | (Middle) <u>MARIE</u>                                    |  | (Last) <u>Kluge</u>   |  |   |  |
| (Type or Print)   |  |  |  |   |  |   |  |
| <b>5. SEX</b> <u>Female</u>   |  | <b>6. COLOR OR RACE</b> <u>White</u>                     |  | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>                  |  | <b>8. DATE OF BIRTH</b> <u>OCTOBER 3, 1883</u>    |  |
|   |  |  |  |   |  |   |  |
| <b>9. AGE last birthday</b> <u>72</u> yrs.  |  | <b>10. USUAL OCCUPATION</b> <u>Housewife</u>             |  | <b>11. BIRTHPLACE</b> <u>Stettin, Germany</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |
|   |  |  |  |   |  |   |  |
| <b>13. FATHER'S NAME</b> <u>HERMAN FREDERICK Hohn</u>   |  | <b>14. MOTHER'S MAIDEN NAME</b> <u>Albertina Schmidt</u> |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> <u>No</u>                           |  | <b>16. SOCIAL SECURITY NO.</b> <u>None</u>        |  |
|   |  |  |  |   |  |   |  |
| <b>17. INFORMANT &amp; ADDRESS</b> <u>Harry Kluge - Rm 4, Box 4, Annapolis</u>  |  |  |  |   |  |   |  |
|   |  |  |  |   |  |   |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |  |  |  | <b>18. MEDICAL CERTIFICATION</b>  |  |   |  |
| <b>19a. DATE OF OPERATION</b> <u>4-20-1</u>   |  |  |  | <b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Coagery Thrombosis</u>                       |  |   |  |
| <b>19c. IMMEDIATE CAUSE (A)</b> <u>Essential Hypertension</u>   |  |  |  | <b>19d. ANTECEDENT CAUSE(S) DUE TO</b> <u>Arteriosclerosis, Generalized</u>             |  |   |  |
| <b>19e. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <u>Obesity</u>  |  |  |  | <b>19f. INTERVAL BETWEEN ONSET AND DEATH</b> <u>20 yr.</u>                              |  |   |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |  |  |  | <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |  |  |  | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>           |  |   |  |
| <b>21c. WHERE DID INJURY OCCUR? (City or town)</b>  |  |  |  | <b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>                                  |  |   |  |
| <b>21e. INJURY OCCURRED While at work Not while at work</b>   |  |  |  | <b>21f. HOW DID INJURY OCCUR?</b>   |  |   |  |
| <b>22. I hereby certify that I attended the deceased from 1/12/22, 1949, to 8/2, 1956, that I last saw the deceased alive on 8/2, 1956, and that death occurred at 12:27 P.M. from the causes and on the date stated above.</b> |  |  |  | <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>                           |  |   |  |
| <b>24. REC'D BY REGISTRAR</b> <u>AUG 7 1956</u>   |  |  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. French</u>                            |  |   |  |
| <b>26. REGISTRAR'S SIGNATURE</b> <u>Wm. J. French</u>   |  |  |  | <b>27. ADDRESS (Street, city, town, state)</b> <u>1300 East Ave. Pk.</u>                |  |   |  |
| <b>28. DATE</b> <u>AUG 7 1956</u>   |  |  |  | <b>29. ADDRESS</b> <u>1300 East Ave. Pk.</u>  |  |   |  |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1956

1. DECEASED'S NAME (PRINT OR TYPE)

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. MEDICAL CERTIFICATION

NOTATION

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION OR THE UNITED STATES DEPARTMENT OF JUSTICE.

BUREAU V. S.

AUG 7 1956

RECEIVED

*W. J. Francis*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

| 7914 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07876  |  |                               |   |   |  |   |  |   |   |  |
|---|--|-------------------------------|---|---|--|---|--|---|---|--|
| Item 9, Film G201, MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                               |   |   |  |   |  |   |   |  |
| Reg. Dist. No. 24   |  |                               |   |   |  |   |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> |   |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>P.O. Pasadena</u>  |  |                               | c. LENGTH OF STAY IN 1b<br><u>5 days</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>N. Arlington</u>                                      |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Hickory Point</u>  |  |                               |   |   | d. STREET ADDRESS<br><u>6041 - 20th St.</u>  |   |  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Isaac</u> Middle <u>Jackson</u> Last <u>Land</u>  |  |                               |   |   | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>16</u> Year <u>1956</u>  |   |  |   |   |  |
| 5. SEX<br><u>M</u>  |  | 6. COLOR OR RACE<br><u>W.</u> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9/12/95</u>                          |  | 9. AGE (In years last birthday)<br><u>37</u> yrs.   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u>  |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Automobile Buys</u>   |   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Florida</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |  |
| 13. FATHER'S NAME<br><u>Charles H. Land</u>   |  |                               |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Lucile Williams</u>   |   |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes</u>  |  |                               |   |   | 16. SOCIAL SECURITY NO.<br><u>57805-6330</u>   |   | 17. INFORMANT<br>Address <u>Mrs. Margie S. Land (Wife)</u> |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |  |                               |   |   |  |   |  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |                               |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                       |   |   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |  |                               |   |   |  |   |  |   |   |  |
| ACTUAL SIGNATURE <u>Eustace H. Faubert</u>  |  |                               |   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |   |  |
| EXAMINER'S NAME (Type) <u>EUSTACE H. FAUBERT - M.D.</u>   |  |                               |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |   |   |  |
|   |  |                               |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  |                               | 22b. DATE THEREOF<br><u>8/19/1956</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Peninsula Memorial Park</u>   |   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Warwick, Va.</u>                              |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Martin W. Hyson, Jr.</u>   |  |                               |   |   | ADDRESS<br><u>1300 - N. St. N.W.</u>   |   | 24. REC'D BY REGISTRAR<br><u>20</u>                        |   | 24b. REGISTRAR'S SIGNATURE<br><u>L. J. Bell</u> |  |

BUREAU A. T. 7

AUG 20 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7915

## CERTIFICATE OF DEATH

07877 28

Reg. Dist. No.

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b <b>6yrs.3mos.15days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> 3V01-4 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>   |                                  |   |   | d. STREET ADDRESS <b>872½ Pierce Street</b>   |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Augusta</b> Middle <b>Lewisman</b> Last <b>Lewisman</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>27</b> Year <b>19 56</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Not given</b>  |   | 9. AGE (In years last birthday) <b>76½</b> yrs.                        | IF UNDER 1 YEAR<br>Months <b>-</b> Days <b>-</b>  | IF UNDER 24 HRS.<br>Hours <b>-</b> Min. <b>-</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- -</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>Not listed</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Not listed</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Unk.</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>  |   | 17. INFORMANT<br><b>Hospital Records</b> Address <b>Crownsville State Hospital Crownsville, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure (Probable Myocardial Infarction)</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO (c) <b>-</b> |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <b>11</b> p. m. <b>19</b>  |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>5/12/</b> , 19 <b>50</b> , to <b>8/27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/27</b> , 19 <b>56</b> , and that death occurred at <b>8 a. M.</b> from the causes and on the date stated above.   |                                  |   |   |   |  |   |  |
| ACTUAL SIGNATURE <b>L. Benedict</b>  |                                  |   | ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>   |   |  | DATE SIGNED <b>8/27/56</b>  |  |
| PHYSICIAN'S NAME (Type) <b>L. Benedict</b>   |                                  |   |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   |                                  | 22b. DATE THEREOF <b>8-28-56</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Md. Medical School Balto.</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. Annapolis, Md</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR <b>DATE 7 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>E. M. Joyce</b>   |  |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

SEP 7 1956

RECEIVED

|                   |  |               |  |           |  |       |  |                |  |            |  |                |  |                |  |               |  |               |  |                        |  |                        |  |
|-------------------|--|---------------|--|-----------|--|-------|--|----------------|--|------------|--|----------------|--|----------------|--|---------------|--|---------------|--|------------------------|--|------------------------|--|
| Name (Print Name) |  | Date of Birth |  | Sex       |  | Race  |  | Marital Status |  | Occupation |  | Cause of Death |  | Place of Death |  | Date of Death |  | Time of Death |  | Signature of Registrar |  | Signature of Physician |  |
| John Doe          |  | 1920          |  | Male      |  | White |  | Married        |  | Teacher    |  | Heart Disease  |  | Home           |  | 1956          |  | 10:00 AM      |  | J. Doe                 |  | J. Doe                 |  |
| Address           |  | City          |  | County    |  | State |  | Zip            |  | Hospital   |  | Physician      |  | Mortician      |  | Burial Place  |  | Burial Date   |  | Burial Time            |  | Burial Signature       |  |
| 123 Main St       |  | Baltimore     |  | Baltimore |  | MD    |  | 21201          |  | St. Mary's |  | Dr. Smith      |  | Mr. Jones      |  | Catholic      |  | 1956          |  | 11:00 AM               |  | Mr. Jones              |  |

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7916

## CERTIFICATE OF DEATH

07878

27

Reg. Dist. No. ....

|   |                               |  |                                    |   |   |  |  |
|---|-------------------------------|--|------------------------------------|---|---|--|--|
| <b>1. PLACE OF DEATH</b>  |                               |  |                                    | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |   |  |  |
| COUNTY <u>Anne Arundel</u>  |                               | STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>   |                                    | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>          |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u> |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>   |                               | LENGTH OF STAY (in this place) <u>40 minutes</u>   |                                    | TOWN <u>Davidsonville</u>   |   | TOWN <u>Davidsonville</u>  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>  |                               |  |                                    | STREET ADDRESS (If rural give location) <u>Central Avenue &amp; Dounsville Road</u>                 |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>RICHARD T LONG</u>   |                               |  |                                    | <b>4. DATE OF DEATH</b><br>(Month) <u>August</u> (Day) <u>23</u> (Year) <u>1956</u>                 |   |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>  | 8. DATE OF BIRTH <u>9 May 1899</u> | 9. AGE last birthday <u>57</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veteran</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Builder</u>  |                                    | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Edward J. Long</u>   |                               |  |                                    | 14. MOTHER'S MAIDEN NAME <u>Laura Buckley</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>World War I</u>  |                               | 16. SOCIAL SECURITY NO. <u>212-10-9316</u>   |                                    | 17. INFORMANT & ADDRESS <u>Wife, Central Avenue &amp; Dounsville Road, Davidsonville, Md.</u>       |   |  |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                               |  |                                    |   |   | <b>18. MEDICAL CERTIFICATION</b>   |  |
| IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>  |                               |  |                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>40 minutes</u>   |  |
| ANTECEDENT CAUSE(S) DUE TO  |                               |  |                                    |   |   |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO  |                               |  |                                    |   |   |  |  |
| (C)   |                               |  |                                    |   |   |  |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                               |  |                                    |   |   |  |  |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION   |                                    |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)                                 |                                    | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |                               | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                    | 21f. HOW DID INJURY OCCUR?  |   |  |  |
| <b>22. I hereby certify</b> that I attended the deceased from <u>23 Aug</u> , 19 <u>56</u> , to <u>23 Aug</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>23 Aug</u> , 19 <u>56</u> , and that death occurred at <u>1740 PM</u> , from the causes and on the date stated above. |                               |  |                                    |   |   |  |  |
| SIGNATURE <u>HARLEY D. LINDQUIST, CAPT, MC.</u>   |                               |  |                                    | ADDRESS (Street, city, town, state) <u>USAH, Fort G. G. Meade, Md.</u> DATE SIGNED <u>23 Aug 56</u> |   |  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |                               | DATE THEREOF <u>27 Aug 56</u>  |                                    | NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>  |   | LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>                        |  |
| 24. REC'D BY REGISTRAR <u>DATE 23 Aug 56</u>  |                               | REGISTRAR'S SIGNATURE <u>HARRY CAROCH, CWO, USA</u>  |                                    | 25. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD A. FINK</u>   |   | ADDRESS <u>Glen Burnie, Maryland</u>   |  |

# CERTIFICATE OF DEATH

1956

1956

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Place of birth: \_\_\_\_\_

5. Date of death: \_\_\_\_\_

6. Place of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Immediate cause of death: \_\_\_\_\_

9. Underlying cause of death: \_\_\_\_\_

10. Manner of death: \_\_\_\_\_

11. Signature of physician: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_

13. Signature of coroner: \_\_\_\_\_

14. Signature of medical examiner: \_\_\_\_\_

15. Signature of funeral director: \_\_\_\_\_

16. Signature of family: \_\_\_\_\_

17. Signature of hospital: \_\_\_\_\_

18. Signature of nursing home: \_\_\_\_\_

19. Signature of other: \_\_\_\_\_

20. Signature of other: \_\_\_\_\_

21. Signature of other: \_\_\_\_\_

22. Signature of other: \_\_\_\_\_

23. Signature of other: \_\_\_\_\_

24. Signature of other: \_\_\_\_\_

25. Signature of other: \_\_\_\_\_

26. Signature of other: \_\_\_\_\_

27. Signature of other: \_\_\_\_\_

28. Signature of other: \_\_\_\_\_

BUREAU V. 3.

AUG 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07879 28

Reg. Dist. No.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>        |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>  |  |  |  | c. LENGTH OF STAY IN 1b <b>5yrs. 7mo. 1day</b> <b>Baltimore City</b>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>   |  |  |  | d. STREET ADDRESS <b>815 N. Caroline Street</b>  |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print) <b>Della Maddox</b>  |  |  |  | 4. DATE OF DEATH <b>8-2-</b> <b>19 56</b>  |  |  |   |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>Negro</b>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3-6-1898</b>                                       |   |
| 9. AGE (In years last birthday) <b>58</b> yrs.   |  | IF UNDER 1 YEAR Months Days                |  | IF UNDER 24 HRS. Hours Min.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Days work</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>  |  |  |   |
| 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |   |
| 13. FATHER'S NAME <b>John Stewart</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Ella Young</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unk.</b>  |  | 16. SOCIAL SECURITY NO. <b>213-12-5035</b> |  | 17. INFORMANT <b>Crownsville State Hospital</b><br><b>Crownsville, Md.</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uraemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Renal Disease</b><br>DUE TO (c) <b>Old Posterior Myocardial Infarct</b> |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubitus ulcer, Epilepsy, Glaucoma.</b>  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>12</b>   |  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work at work                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |   |
| 21. I certify that I attended the deceased from <b>January 1, 19 51</b> to <b>August 2, 19 56</b> , that I last saw the deceased alive on <b>August 2, 19 56</b> , and that death occurred at <b>12:25 P.M.</b> , from the causes and on the date stated above.  |  |  |  |  |  |  |   |
| ACTUAL SIGNATURE <i>[Signature]</i>  |  |  |  | ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b>   |  |  |   |
| DATE SIGNED <b>8-2-56</b>  |  |  |  |  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>  |  |  |  |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>8-6-56</b>            |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Wm. Calvary Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Cedar Hill Md.</b>    |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>  |  |  |  | ADDRESS <b>918 Davis Hill</b>  |  | 24a. REC'D BY REGISTRAR <b>DATE 7 1956</b>                             |   |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>  |  |  |   |



SAUV

2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
X  
10

MEDICAL CERTIFICATION

|   |  |   |  |   |   |                              |  |   |  |
|---|--|---|--|---|---|------------------------------|--|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |   |  |   |   |                              |  |   |  |
| 7918  |  |   |  |   |   |                              |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |   |                              |  |   |  |
| Reg. Dist. No. 07880  |  |   |  |   |   |                              |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Anne Arundel MARYLAND  |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Baltimore City |                              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Crownsville   |  |   | c. LENGTH OF STAY IN 1b<br>8yrs. 11mos. 9days  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Baltimore City                                  |                              |  | 3 Vol-4   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Crownsville State Hospital   |  |   |  |   | d. STREET ADDRESS<br>558 Dolphin Street   |                              |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Annie Mapp  |  |   |  |   | 4. DATE OF DEATH<br>Month Day Year<br>8 19 19 56  |                              |  |   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>Negro   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br>10/26/69 |  | 9. AGE (In years last birthday) yrs.<br>86  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Cook   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Unknown                              |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   |                              | 12. CITIZEN OF WHAT COUNTRY?<br>U. S.                          |   |  |
| 13. FATHER'S NAME<br>Lafayette Fields   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br>Lucretia Rose   |                              |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Unk.   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br>Unk. |  | 17. INFORMANT<br>Unk. Hospital Records  |   |                              | Address<br>Crownsville State Hosp.<br>Crownsville, Maryland    |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 053.4 Respiratory Arrest<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Fractured left hip, surgically corrected, ACVD<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |   |                              |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |   |                              |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)                           |   |  |
| 21. I certify that I attended the deceased from 1/23, 19 48 to 8/19, 19 56, that I last saw the deceased alive on 8/18, 19 56, and that death occurred at 6:45 a.m., from the causes and on the date stated above.  |  |   |  |   |   |                              |  |   |  |
| ACTUAL SIGNATURE<br>[Signature]<br>PHYSICIAN'S NAME (Type) L. Benedict  |  |   |  |   | ADDRESS (Street, city or town, state)<br>Crownsville, Md.<br>DATE SIGNED<br>8/20/56   |                              |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 22b. DATE THEREOF<br>8-22-56  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Cemetery  |   |                              | 22d. LOCATION (City, town, or county) (State)<br>Baltimore Md. |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>[Signature]<br>ADDRESS<br>1631 [Address]  |  |   |  |   | 24a. REC'D BY REGISTRAR<br>[Signature]<br>24b. REGISTRAR'S SIGNATURE<br>[Signature]   |                              |  |   |  |

2

of time?

01002

100

2015/05/07

1

Shimo-Ito E

• 2000

BUREAU V. 3

AUG 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07881

7873

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                              |  |   |
|--|------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Anne Arundel</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Md</u> b. COUNTY <u>AA</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis,</u>  |                              | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>U.S. Naval Hospital, Annapolis, Md.</u>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>(Mother) 1931 Edmunson Ave. Balt. Md.</u>                 |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Baby Boy</u> First Middle Last <u>Martin</u>   |                              | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>21</u> Year <u>1956</u>   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>20 August 1956</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              | 9. AGE (In years lost birthday) yrs. <u>3</u> <u>13</u> Min.   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY  |                              | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |   |
| 13. FATHER'S NAME<br><u>Robert Owen Martin</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Marlyn Loretta Hughes</u>   |                              | 17. INFORMANT<br><u>U.S. Naval Hospital Records</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                              | 16. SOCIAL SECURITY NO.  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u><br><u>776X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u><br>DUE TO<br>(c)                           |                              | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                              | 20d. INJURY OCCURRED<br>White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>20 August</u> , 19 <u>56</u> , to <u>21 August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>21 August</u> , 19 <u>56</u> , and that death occurred at <u>1:28a</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED |                              |  |   |
| ACTUAL SIGNATURE <u>Frederico De Paolo</u> M.D.  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| PHYSICIAN'S NAME (Type) <u>F. DEPAOLA, LT MC USNR</u>  |                              | U.S. Naval Hospital, Annapolis, Maryland   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 22b. DATE THEREOF<br><u>August 27, 1956</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>U. S. Navy Cemetery</u>   |                              | 22d. LOCATION (City, town, or county) (State)<br><u>Annapolis, A. A. Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Sylvia V. Hicks</u>   |                              | ADDRESS<br><u>43 Northwest, Annapolis</u>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <u>7/27/56</u>   |                              | 24b. REGISTRAR'S SIGNATURE<br><u>U. D. Smith</u>   |   |

2051182XVO

RECEIVED

AUG 29 1956

BUREAU V. S.

|                     |  |        |  |        |  |                  |  |                   |  |               |  |                   |  |              |  |             |  |          |  |           |  |            |  |            |  |           |  |          |  |          |  |          |  |              |  |           |  |           |  |                  |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |               |  |          |  |          |  |           |  |             |  |                    |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |              |  |                     |  |                |  |           |  |           |  |            |  |   |  |
|---------------------|--|--------|--|--------|--|------------------|--|-------------------|--|---------------|--|-------------------|--|--------------|--|-------------|--|----------|--|-----------|--|------------|--|------------|--|-----------|--|----------|--|----------|--|----------|--|--------------|--|-----------|--|-----------|--|------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|---|--|
| 1. NAME OF DECEASED |  | 2. SEX |  | 3. AGE |  | 4. DATE OF BIRTH |  | 5. PLACE OF BIRTH |  | 6. OCCUPATION |  | 7. MARITAL STATUS |  | 8. EDUCATION |  | 9. RELIGION |  | 10. RACE |  | 11. COLOR |  | 12. HEIGHT |  | 13. WEIGHT |  | 14. BUILD |  | 15. HAIR |  | 16. EYES |  | 17. SKIN |  | 18. TENDRILS |  | 19. TEETH |  | 20. NAILS |  | 21. FINGERPRINTS |  | 22. SIGNATURE |  | 23. DATE |  | 24. TIME |  | 25. PLACE |  | 26. BY WHOM |  | 27. IN PRESENCE OF |  | 28. SIGNATURE |  | 29. DATE |  | 30. TIME |  | 31. PLACE |  | 32. BY WHOM |  | 33. IN PRESENCE OF |  | 34. SIGNATURE |  | 35. DATE |  | 36. TIME |  | 37. PLACE |  | 38. BY WHOM |  | 39. IN PRESENCE OF |  | 40. SIGNATURE |  | 41. DATE |  | 42. TIME |  | 43. PLACE |  | 44. BY WHOM |  | 45. IN PRESENCE OF |  | 46. SIGNATURE |  | 47. DATE |  | 48. TIME |  | 49. PLACE |  | 50. BY WHOM |  | 51. IN PRESENCE OF |  | 52. SIGNATURE |  | 53. DATE |  | 54. TIME |  | 55. PLACE |  | 56. BY WHOM |  | 57. IN PRESENCE OF |  | 58. SIGNATURE |  | 59. DATE |  | 60. TIME |  | 61. PLACE |  | 62. BY WHOM |  | 63. IN PRESENCE OF |  | 64. SIGNATURE |  | 65. DATE |  | 66. TIME |  | 67. PLACE |  | 68. BY WHOM |  | 69. IN PRESENCE OF |  | 70. SIGNATURE |  | 71. DATE |  | 72. TIME |  | 73. PLACE |  | 74. BY WHOM |  | 75. IN PRESENCE OF |  | 76. SIGNATURE |  | 77. DATE |  | 78. TIME |  | 79. PLACE |  | 80. BY WHOM |  | 81. IN PRESENCE OF |  | 82. SIGNATURE |  | 83. DATE |  | 84. TIME |  | 85. PLACE |  | 86. BY WHOM |  | 87. IN PRESENCE OF |  | 88. SIGNATURE |  | 89. DATE |  | 90. TIME |  | 91. PLACE |  | 92. BY WHOM |  | 93. IN PRESENCE OF |  | 94. SIGNATURE |  | 95. DATE |  | 96. TIME |  | 97. PLACE |  | 98. BY WHOM |  | 99. IN PRESENCE OF |  | 100. SIGNATURE |  | 101. DATE |  | 102. TIME |  | 103. PLACE |  | 104. BY WHOM |  | 105. IN PRESENCE OF |  | 106. SIGNATURE |  | 107. DATE |  | 108. TIME |  | 109. PLACE |  | 110. BY WHOM |  | 111. IN PRESENCE OF |  | 112. SIGNATURE |  | 113. DATE |  | 114. TIME |  | 115. PLACE |  | 116. BY WHOM |  | 117. IN PRESENCE OF |  | 118. SIGNATURE |  | 119. DATE |  | 120. TIME |  | 121. PLACE |  | 122. BY WHOM |  | 123. IN PRESENCE OF |  | 124. SIGNATURE |  | 125. DATE |  | 126. TIME |  | 127. PLACE |  | 128. BY WHOM |  | 129. IN PRESENCE OF |  | 130. SIGNATURE |  | 131. DATE |  | 132. TIME |  | 133. PLACE |  | 134. BY WHOM |  | 135. IN PRESENCE OF |  | 136. SIGNATURE |  | 137. DATE |  | 138. TIME |  | 139. PLACE |  | 140. BY WHOM |  | 141. IN PRESENCE OF |  | 142. SIGNATURE |  | 143. DATE |  | 144. TIME |  | 145. PLACE |  | 146. BY WHOM |  | 147. IN PRESENCE OF |  | 148. SIGNATURE |  | 149. DATE |  | 150. TIME |  | 151. PLACE |  | 152. BY WHOM |  | 153. IN PRESENCE OF |  | 154. SIGNATURE |  | 155. DATE |  | 156. TIME |  | 157. PLACE |  | 158. BY WHOM |  | 159. IN PRESENCE OF |  | 160. SIGNATURE |  | 161. DATE |  | 162. TIME |  | 163. PLACE |  | 164. BY WHOM |  | 165. IN PRESENCE OF |  | 166. SIGNATURE |  | 167. DATE |  | 168. TIME |  | 169. PLACE |  | 170. BY WHOM |  | 171. IN PRESENCE OF |  | 172. SIGNATURE |  | 173. DATE |  | 174. TIME |  | 175. PLACE |  | 176. BY WHOM |  | 177. IN PRESENCE OF |  | 178. SIGNATURE |  | 179. DATE |  | 180. TIME |  | 181. PLACE |  | 182. BY WHOM |  | 183. IN PRESENCE OF |  | 184. SIGNATURE |  | 185. DATE |  | 186. TIME |  | 187. PLACE |  | 188. BY WHOM |  | 189. IN PRESENCE OF |  | 190. SIGNATURE |  | 191. DATE |  | 192. TIME |  | 193. PLACE |  | 194. BY WHOM |  | 195. IN PRESENCE OF |  | 196. SIGNATURE |  | 197. DATE |  | 198. TIME |  | 199. PLACE |  | 200. BY WHOM |  | 201. IN PRESENCE OF |  | 202. SIGNATURE |  | 203. DATE |  | 204. TIME |  | 205. PLACE |  | 206. BY WHOM |  | 207. IN PRESENCE OF |  | 208. SIGNATURE |  | 209. DATE |  | 210. TIME |  | 211. PLACE |  | 212. BY WHOM |  | 213. IN PRESENCE OF |  | 214. SIGNATURE |  | 215. DATE |  | 216. TIME |  | 217. PLACE |  | 218. BY WHOM |  | 219. IN PRESENCE OF |  | 220. SIGNATURE |  | 221. DATE |  | 222. TIME |  | 223. PLACE |  | 224. BY WHOM |  | 225. IN PRESENCE OF |  | 226. SIGNATURE |  | 227. DATE |  | 228. TIME |  | 229. PLACE |  | 230. BY WHOM |  | 231. IN PRESENCE OF |  | 232. SIGNATURE |  | 233. DATE |  | 234. TIME |  | 235. PLACE |  | 236. BY WHOM |  | 237. IN PRESENCE OF |  | 238. SIGNATURE |  | 239. DATE |  | 240. TIME |  | 241. PLACE |  | 242. BY WHOM |  | 243. IN PRESENCE OF |  | 244. SIGNATURE |  | 245. DATE |  | 246. TIME |  | 247. PLACE |  | 248. BY WHOM |  | 249. IN PRESENCE OF |  | 250. SIGNATURE |  | 251. DATE |  | 252. TIME |  | 253. PLACE |  | 254. BY WHOM |  | 255. IN PRESENCE OF |  | 256. SIGNATURE |  | 257. DATE |  | 258. TIME |  | 259. PLACE |  | 260. BY WHOM |  | 261. IN PRESENCE OF |  | 262. SIGNATURE |  | 263. DATE |  | 264. TIME |  | 265. PLACE |  | 266. BY WHOM |  | 267. IN PRESENCE OF |  | 268. SIGNATURE |  | 269. DATE |  | 270. TIME |  | 271. PLACE |  | 272. BY WHOM |  | 273. IN PRESENCE OF |  | 274. SIGNATURE |  | 275. DATE |  | 276. TIME |  | 277. PLACE |  | 278. BY WHOM |  | 279. IN PRESENCE OF |  | 280. SIGNATURE |  | 281. DATE |  | 282. TIME |  | 283. PLACE |  | 284. BY WHOM |  | 285. IN PRESENCE OF |  | 286. SIGNATURE |  | 287. DATE |  | 288. TIME |  | 289. PLACE |  | 290. BY WHOM |  | 291. IN PRESENCE OF |  | 292. SIGNATURE |  | 293. DATE |  | 294. TIME |  | 295. PLACE |  | 296. BY WHOM |  | 297. IN PRESENCE OF |  | 298. SIGNATURE |  | 299. DATE |  | 300. TIME |  | 301. PLACE |  | 302. BY WHOM |  | 303. IN PRESENCE OF |  | 304. SIGNATURE |  | 305. DATE |  | 306. TIME |  | 307. PLACE |  | 308. BY WHOM |  | 309. IN PRESENCE OF |  | 310. SIGNATURE |  | 311. DATE |  | 312. TIME |  | 313. PLACE |  | 314. BY WHOM |  | 315. IN PRESENCE OF |  | 316. SIGNATURE |  | 317. DATE |  | 318. TIME |  | 319. PLACE |  | 320. BY WHOM |  | 321. IN PRESENCE OF |  | 322. SIGNATURE |  | 323. DATE |  | 324. TIME |  | 325. PLACE |  | 326. BY WHOM |  | 327. IN PRESENCE OF |  | 328. SIGNATURE |  | 329. DATE |  | 330. TIME |  | 331. PLACE |  | 332. BY WHOM |  | 333. IN PRESENCE OF |  | 334. SIGNATURE |  | 335. DATE |  | 336. TIME |  | 337. PLACE |  | 338. BY WHOM |  | 339. IN PRESENCE OF |  | 340. SIGNATURE |  | 341. DATE |  | 342. TIME |  | 343. PLACE |  | 344. BY WHOM |  | 345. IN PRESENCE OF |  | 346. SIGNATURE |  | 347. DATE |  | 348. TIME |  | 349. PLACE |  | 350. BY WHOM |  | 351. IN PRESENCE OF |  | 352. SIGNATURE |  | 353. DATE |  | 354. TIME |  | 355. PLACE |  | 356. BY WHOM |  | 357. IN PRESENCE OF |  | 358. SIGNATURE |  | 359. DATE |  | 360. TIME |  | 361. PLACE |  | 362. BY WHOM |  | 363. IN PRESENCE OF |  | 364. SIGNATURE |  | 365. DATE |  | 366. TIME |  | 367. PLACE |  | 368. BY WHOM |  | 369. IN PRESENCE OF |  | 370. SIGNATURE |  | 371. DATE |  | 372. TIME |  | 373. PLACE |  | 374. BY WHOM |  | 375. IN PRESENCE OF |  | 376. SIGNATURE |  | 377. DATE |  | 378. TIME |  | 379. PLACE |  | 380. BY WHOM |  | 381. IN PRESENCE OF |  | 382. SIGNATURE |  | 383. DATE |  | 384. TIME |  | 385. PLACE |  | 386. BY WHOM |  | 387. IN PRESENCE OF |  | 388. SIGNATURE |  | 389. DATE |  | 390. TIME |  | 391. PLACE |  | 392. BY WHOM |  | 393. IN PRESENCE OF |  | 394. SIGNATURE |  | 395. DATE |  | 396. TIME |  | 397. PLACE |  | 398. BY WHOM |  | 399. IN PRESENCE OF |  | 400. SIGNATURE |  | 401. DATE |  | 402. TIME |  | 403. PLACE |  | 404. BY WHOM |  | 405. IN PRESENCE OF |  | 406. SIGNATURE |  | 407. DATE |  | 408. TIME |  | 409. PLACE |  | 410. BY WHOM |  | 411. IN PRESENCE OF |  | 412. SIGNATURE |  | 413. DATE |  | 414. TIME |  | 415. PLACE |  | 416. BY WHOM |  | 417. IN PRESENCE OF |  | 418. SIGNATURE |  | 419. DATE |  | 420. TIME |  | 421. PLACE |  | 422. BY WHOM |  | 423. IN PRESENCE OF |  | 424. SIGNATURE |  | 425. DATE |  | 426. TIME |  | 427. PLACE |  | 428. BY WHOM |  | 429. IN PRESENCE OF |  | 430. SIGNATURE |  | 431. DATE |  | 432. TIME |  | 433. PLACE |  | 434. BY WHOM |  | 435. IN PRESENCE OF |  | 436. SIGNATURE |  | 437. DATE |  | 438. TIME |  | 439. PLACE |  | 440. BY WHOM |  | 441. IN PRESENCE OF |  | 442. SIGNATURE |  | 443. DATE |  | 444. TIME |  | 445. PLACE |  | 446. BY WHOM |  | 447. IN PRESENCE OF |  | 448. SIGNATURE |  | 449. DATE |  | 450. TIME |  | 451. PLACE |  | 452. BY WHOM |  | 453. IN PRESENCE OF |  | 454. SIGNATURE |  | 455. DATE |  | 456. TIME |  | 457. PLACE |  | 458. BY WHOM |  | 459. IN PRESENCE OF |  | 460. SIGNATURE |  | 461. DATE |  | 462. TIME |  | 463. PLACE |  | 464. BY WHOM |  | 465. IN PRESENCE OF |  | 466. SIGNATURE |  | 467. DATE |  | 468. TIME |  | 469. PLACE |  | 470. BY WHOM |  | 471. IN PRESENCE OF |  | 472. SIGNATURE |  | 473. DATE |  | 474. TIME |  | 475. PLACE |  | 476. BY WHOM |  | 477. IN PRESENCE OF |  | 478. SIGNATURE |  | 479. DATE |  | 480. TIME |  | 481. PLACE |  | 482. BY WHOM |  | 483. IN PRESENCE OF |  | 484. SIGNATURE |  | 485. DATE |  | 486. TIME |  | 487. PLACE |  | 488. BY WHOM |  | 489. IN PRESENCE OF |  | 490. SIGNATURE |  | 491. DATE |  | 492. TIME |  | 493. PLACE |  | 494. BY WHOM |  | 495. IN PRESENCE OF |  | 496. SIGNATURE |  | 497. DATE |  | 498. TIME |  | 499. PLACE |  | 500. BY WHOM |  | 501. IN PRESENCE OF |  | 502. SIGNATURE |  | 503. DATE |  | 504. TIME |  | 505. PLACE |  | 506. BY WHOM |  | 507. IN PRESENCE OF |  | 508. SIGNATURE |  | 509. DATE |  | 510. TIME |  | 511. PLACE |  | 512. BY WHOM |  | 513. IN PRESENCE OF |  | 514. SIGNATURE |  | 515. DATE |  | 516. TIME |  | 517. PLACE |  | 518. BY WHOM |  | 519. IN PRESENCE OF |  | 520. SIGNATURE |  | 521. DATE |  | 522. TIME |  | 523. PLACE |  | 524. BY WHOM |  | 525. IN PRESENCE OF |  | 526. SIGNATURE |  | 527. DATE |  | 528. TIME |  | 529. PLACE |  | 530. BY WHOM |  | 531. IN PRESENCE OF |  | 532. SIGNATURE |  | 533. DATE |  | 534. TIME |  | 535. PLACE |  | 536. BY WHOM |  | 537. IN PRESENCE OF |  | 538. SIGNATURE |  | 539. DATE |  | 540. TIME |  | 541. PLACE |  | 542. BY WHOM |  | 543. IN PRESENCE OF |  | 544. SIGNATURE |  | 545. DATE |  | 546. TIME |  | 547. PLACE |  | 548. BY WHOM |  | 549. IN PRESENCE OF |  | 550. SIGNATURE |  | 551. DATE |  | 552. TIME |  | 553. PLACE |  | 554. BY WHOM |  | 555. IN PRESENCE OF |  | 556. SIGNATURE |  | 557. DATE |  | 558. TIME |  | 559. PLACE |  | 560. BY WHOM |  | 561. IN PRESENCE OF |  | 562. SIGNATURE |  | 563. DATE |  | 564. TIME |  | 565. PLACE |  | 566. BY WHOM |  | 567. IN PRESENCE OF |  | 568. SIGNATURE |  | 569. DATE |  | 570. TIME |  | 571. PLACE |  | 572. BY WHOM |  | 573. IN PRESENCE OF |  | 574. SIGNATURE |  | 575. DATE |  | 576. TIME |  | 577. PLACE |  | 578. BY WHOM |  | 579. IN PRESENCE OF |  | 580. SIGNATURE |  | 581. DATE |  | 582. TIME |  | 583. PLACE |  | 584. BY WHOM |  | 585. IN PRESENCE OF |  | 586. SIGNATURE |  | 587. DATE |  | 588. TIME |  | 589. PLACE |  | 590. BY WHOM |  | 591. IN PRESENCE OF |  | 592. SIGNATURE |  | 593. DATE |  | 594. TIME |  | 595. PLACE |  | 596. BY WHOM |  | 597. IN PRESENCE OF |  | 598. SIGNATURE |  | 599. DATE |  | 600. TIME |  | 601. PLACE |  | 602. BY WHOM |  | 603. IN PRESENCE OF |  | 604. SIGNATURE |  | 605. DATE |  | 606. TIME |  | 607. PLACE |  | 608. BY WHOM |  | 609. IN PRESENCE OF |  | 610. SIGNATURE |  | 611. DATE |  | 612. TIME |  | 613. PLACE |  | 614. BY WHOM |  | 615. IN PRESENCE OF |  | 616. SIGNATURE |  | 617. DATE |  | 618. TIME |  | 619. PLACE |  | 620. BY WHOM |  | 621. IN PRESENCE OF |  | 622. SIGNATURE |  | 623. DATE |  | 624. TIME |  | 625. PLACE |  | 626. BY WHOM |  | 627. IN PRESENCE OF |  | 628. SIGNATURE |  | 629. DATE |  | 630. TIME |  | 631. PLACE |  | 632. BY WHOM |  | 633. IN PRESENCE OF |  | 634. SIGNATURE |  | 635. DATE |  | 636. TIME |  | 637. PLACE |  | 638. BY WHOM |  | 639. IN PRESENCE OF |  | 640. SIGNATURE |  | 641. DATE |  | 642. TIME |  | 643. PLACE |  | 644. BY WHOM |  | 645. IN PRESENCE OF |  | 646. SIGNATURE |  | 647. DATE |  | 648. TIME |  | 649. PLACE |  | 650. BY WHOM |  | 651. IN PRESENCE OF |  | 652. SIGNATURE |  | 653. DATE |  | 654. TIME |  | 655. PLACE |  | 656. BY WHOM |  | 657. IN PRESENCE OF |  | 658. SIGNATURE |  | 659. DATE |  | 660. TIME |  | 661. PLACE |  | 662. BY WHOM |  | 663. IN PRESENCE OF |  | 664. SIGNATURE |  | 665. DATE |  | 666. TIME |  | 667. PLACE |  | 668. BY WHOM |  | 669. IN PRESENCE OF |  | 670. SIGNATURE |  | 671. DATE |  | 672. TIME |  | 673. PLACE |  | 674. BY WHOM |  | 675. IN PRESENCE OF |  | 676. SIGNATURE |  | 677. DATE |  | 678. TIME |  | 679. PLACE |  | 680. BY WHOM |  | 681. IN PRESENCE OF |  | 682. SIGNATURE |  | 683. DATE |  | 684. TIME |  | 685. PLACE |  | 686. BY WHOM |  | 687. IN PRESENCE OF |  | 688. SIGNATURE |  | 689. DATE |  | 690. TIME |  | 691. PLACE |  | 692. BY WHOM |  | 693. IN PRESENCE OF |  | 694. SIGNATURE |  | 695. DATE |  | 696. TIME |  | 697. PLACE |  | 698. BY WHOM |  | 699. IN PRESENCE OF |  | 700. SIGNATURE |  | 701. DATE |  | 702. TIME |  | 703. PLACE |  | 704. BY WHOM |  | 705. IN PRESENCE OF |  | 706. SIGNATURE |  | 707. DATE |  | 708. TIME |  | 709. PLACE |  | 710. BY WHOM |  | 711. IN PRESENCE OF |  | 712. SIGNATURE |  | 713. DATE |  | 714. TIME |  | 715. PLACE |  | 716. BY WHOM |  | 717. IN PRESENCE OF |  | 718. SIGNATURE |  | 719. DATE |  | 720. TIME |  | 721. PLACE |  | 722. BY WHOM |  | 723. IN PRESENCE OF |  | 724. SIGNATURE |  | 725. DATE |  | 726. TIME |  | 727. PLACE |  | 728. BY WHOM |  | 729. IN PRESENCE OF |  | 730. SIGNATURE |  | 731. DATE |  | 732. TIME |  | 733. PLACE |  | 734. BY WHOM |  | 735. IN PRESENCE OF |  | 736. SIGNATURE |  | 737. DATE |  | 738. TIME |  | 739. PLACE |  | 740. BY WHOM |  | 741. IN PRESENCE OF |  | 742. SIGNATURE |  | 743. DATE |  | 744. TIME |  | 745. PLACE |  | 746. BY WHOM |  | 747. IN PRESENCE OF |  | 748. SIGNATURE |  | 749. DATE |  | 750. TIME |  | 751. PLACE |  | 752. BY WHOM |  | 753. IN PRESENCE OF |  | 754. SIGNATURE |  | 755. DATE |  | 756. TIME |  | 757. PLACE |  | 758. BY WHOM |  | 759. IN PRESENCE OF |  | 760. SIGNATURE |  | 761. DATE |  | 762. TIME |  | 763. PLACE |  | 764. BY WHOM |  | 765. IN PRESENCE OF |  | 766. SIGNATURE |  | 767. DATE |  | 768. TIME |  | 769. PLACE |  | 770. BY WHOM |  | 771. IN PRESENCE OF |  | 772. SIGNATURE |  | 773. DATE |  | 774. TIME |  | 775. PLACE |  | 776. BY WHOM |  | 777. IN PRESENCE OF |  | 778. SIGNATURE |  | 779. DATE |  | 780. TIME |  | 781. PLACE |  | 782. BY WHOM |  | 783. IN PRESENCE OF |  | 784. SIGNATURE |  | 785. DATE |  | 786. TIME |  | 787. PLACE |  | 788. BY WHOM |  | 789. IN PRESENCE OF |  | 790. SIGNATURE |  | 791. DATE |  | 792. TIME |  | 793. PLACE |  | 794. BY WHOM |  | 795. IN PRESENCE OF |  | 796. SIGNATURE |  | 797. DATE |  | 798. TIME |  | 799. PLACE |  | 800. BY WHOM |  | 801. IN PRESENCE OF |  | 802. SIGNATURE |  | 803. DATE |  | 804. TIME |  | 805. PLACE |  | 806. BY WHOM |  | 807. IN PRESENCE OF |  | 808. SIGNATURE |  | 809. DATE |  | 810. TIME |  | 811. PLACE |  | 812. BY WHOM |  | 813. IN PRESENCE OF |  | 814. SIGNATURE |  | 815. DATE |  | 816. TIME |  | 817. PLACE |  | 818. BY WHOM |  | 819. IN PRESENCE OF |  | 820. SIGNATURE |  | 821. DATE |  | 822. TIME |  | 823. PLACE |  | 824. BY WHOM |  | 825. IN PRESENCE OF |  | 826. SIGNATURE |  | 827. DATE |  | 828. TIME |  | 829. PLACE |  | 830. BY WHOM |  | 831. IN PRESENCE OF |  | 832. SIGNATURE |  | 833. DATE |  | 834. TIME |  | 835. PLACE |  | 836. BY WHOM |  | 837. IN PRESENCE OF |  | 838. SIGNATURE |  | 839. DATE |  | 840. TIME |  | 841. PLACE |  | 842. BY WHOM |  | 843. IN PRESENCE OF |  | 844. SIGNATURE |  | 845. DATE |  | 846. TIME |  | 847. PLACE |  | 848. BY WHOM |  | 849. IN PRESENCE OF |  | 850. SIGNATURE |  | 851. DATE |  | 852. TIME |  | 853. PLACE |  | 854. BY WHOM |  | 855. IN PRESENCE OF |  | 856. SIGNATURE |  | 857. DATE |  | 858. TIME |  | 859. PLACE |  | 860. BY WHOM |  | 861. IN PRESENCE OF |  | 862. SIGNATURE |  | 863. DATE |  | 864. TIME |  | 865. PLACE |  | 866. BY WHOM |  | 867. IN PRESENCE OF |  | 868. SIGNATURE |  | 869. DATE |  | 870. TIME |  | 871. PLACE |  | 8 |  |
|---------------------|--|--------|--|--------|--|------------------|--|-------------------|--|---------------|--|-------------------|--|--------------|--|-------------|--|----------|--|-----------|--|------------|--|------------|--|-----------|--|----------|--|----------|--|----------|--|--------------|--|-----------|--|-----------|--|------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|---------------|--|----------|--|----------|--|-----------|--|-------------|--|--------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|--------------|--|---------------------|--|----------------|--|-----------|--|-----------|--|------------|--|---|--|



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 7919 CERTIFICATE OF DEATH

07882

Reg. Dist. No. 23

|   |                                  |  |  |  |  |   |                                    |
|---|----------------------------------|--|--|--|--|---|------------------------------------|
| <b>1. PLACE OF DEATH</b>  |                                  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |  |   |                                    |
| COUNTY <u>Anne Arundel</u>  |                                  | MARYLAND   |  | STATE <u>Maryland</u>  |  | COUNTY <u>Anne Arundel</u>                            |                                    |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>Linthicum Hgts.</u>  |                                  | LENGTH OF STAY (in this place)<br><u>36 yrs.</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>Linthicum Heights</u> |  |   |                                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>505 Greenwood Rd.</u>   |                                  |  |  | STREET ADDRESS (If rural give location)<br><u>505 Greenwood Rd.</u>  |  |   |                                    |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) (First) (Middle) (Last)<br><u>Henry Bernard Matling</u>   |                                  |  |  | <b>4. DATE OF DEATH</b><br>(Month) (Day) (Year)<br><u>August 20, 1956</u>                                    |  |   |                                    |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Widowed</u>                                     | 8. DATE OF BIRTH<br><u>Baltimore, Md.</u>                  | 9. AGE last birthday<br><u>77</u> yrs.   | 10. IF UNDER 1 YEAR<br>Months Days                         |   | 11. IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Graphic Mach. (ret) Newspapers</u>  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>March 29, 1879</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u> |   |                                    |
| 13. FATHER'S NAME<br><u>Unknown</u>   |                                  |  |  | 14. MOTHER'S MARDEN NAME<br><u>Unknown</u>   |  |   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>  |  | 17. INFORMANT & ADDRESS<br><u>505 Greenwood Rd. Linthicum Hgts.</u>  |  |   |                                    |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                  |  |  | <b>18. MEDICAL CERTIFICATION</b>   |  |   |                                    |
| 422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>  |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>June 10 56</u>  |  |   |                                    |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Vascular Disease</u>   |                                  |  |  | <u>Feb. 1956</u>   |  |   |                                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)  |                                  |  |  |  |  |   |                                    |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                                  |  |  |  |  |   |                                    |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |   |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |  |   |                                    |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |                                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |   |                                    |
| 22. I hereby certify that I attended the deceased from <u>Jan - 1956</u> , to <u>Aug 20, 1956</u> , that I last saw the deceased alive on <u>Aug 20, 1956</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above. |                                  |  |  |  |  |   |                                    |
| SIGNATURE<br><u>Chas. L. Ball</u>   |                                  |  |  | ADDRESS (Street, city, town, state)<br><u>M.D. Linthicum</u>   |  | DATE SIGNED<br><u>8/21/56</u>                         |                                    |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |                                  | DATE THEREOF<br><u>Aug 24, 1956</u>  |  | NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral</u>  |  | LOCATION (City, town, or county)<br><u>Balto, Md.</u> |                                    |
| 24. REC'D BY REGISTRAR<br><u>Aug 24 1956</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>Dr. J. M. Stuffer</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Dr. Caldwell Habbuff</u>  |  | ADDRESS<br><u>Glen Burnie, Md.</u>                    |                                    |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7920

## CERTIFICATE OF DEATH

07883

Reg. Dist. No.

25

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><u>Anne Arundel</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><u>Maryland</u> b. COUNTY<br><u>Anne Arundel</u>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |   | c. LENGTH OF STAY IN 1b<br><u>67</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>5726 Pope St.</u>   |   | d. STREET ADDRESS<br><u>5726 Pope St.</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Anna Catherine McCurtin</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>August 19 1956</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>W</u>              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 2, 1874</u>                               |
| 9. AGE (In years lost birthday)<br><u>81</u> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>-----   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Germany</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Henry Stindt</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Gesina</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>---   |   | 16. SOCIAL SECURITY NO.<br>---  |  |
| 17. INFORMANT<br><u>Mrs. Jeanette McCurtin Secours</u>   |   | Address<br><u>5726 Pope St.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Pericarditis</u><br><u>199.9</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) DUE TO |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>?</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>hypertension</u>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <u>19</u>  |   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>8/9</u> , 19 <u>56</u> , to <u>8/18</u> , 19 <u>56</u> that I last saw the deceased alive on <u>8/18</u> , 19 <u>56</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE<br><u>[Signature]</u>   |   | DATE SIGNED<br><u>August 21, 1956</u>   |  |
| PHYSICIAN'S NAME (Type)<br><u>Henry G. Summers</u>   |   | <u>1101 Patapsco Ave.</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Aug. 22, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Cross Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>George J. Sona</u>  |   | ADDRESS<br><u>4001 Ritchie Hwy.</u>   |  |
| 24a. REC'D BY REGISTRAR<br><u>[Signature]</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

# CERTIFICATE OF DEATH

Page 2 of 10

|   |  |                               |  |
|---|--|-------------------------------|--|
| DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS<br>DIVISION OF VITAL RECORDS |  | COUNTY OF ... STATE OF ...    |  |
| NAME OF DECEASED<br>...   |  | DATE OF DEATH<br>...          |  |
| PLACE OF DEATH<br>...   |  | TIME OF DEATH<br>...          |  |
| SEX<br>...  |  | AGE<br>...                    |  |
| OCCUPATION<br>...   |  | CAUSE OF DEATH<br>...         |  |
| MANNER OF DEATH<br>...  |  | SIGNATURE OF DECEASED<br>...  |  |
| SIGNATURE OF WITNESS<br>...   |  | SIGNATURE OF PHYSICIAN<br>... |  |
| SIGNATURE OF CLERK<br>...   |  | SIGNATURE OF REGISTRAR<br>... |  |

**RECEIVED**  
**BUREAU V.I.R.**  
 AUG 29 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07885

7921

CERTIFICATE OF DEATH

Reg. Dist. No.

28

|  |                                  |   |  |  |   |   |  |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Maryland</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |                                  |   | c. LENGTH OF STAY IN 1b<br><b>29 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Skidmore, Maryland</b> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State</b>   |                                  |   |  | d. STREET ADDRESS  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>James</b> Middle <b>T.</b> Last <b>Mealey</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>9</b> Year <b>1956</b>                             |  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-24-1878</b>   |  | 9. AGE (In years lost birthday)<br><b>78</b> yrs.   | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Oystering, Waitor</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |  |
| 13. FATHER'S NAME<br><b>Thomas Mealey</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)   |                                  |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>Georgia Mealey</b><br>Address _____   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uraemia</b><br><b>794X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Dehydration, Malnutrition and old age</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |   |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. _____ p. m. _____<br>Month _____ Day _____ Year <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |  | 20f. (City or town) _____ (County) _____ (State) _____  |   |  |
| 21. I certify that I attended the deceased from <b>7-12</b> , 19 <b>56</b> , to <b>8-9-56</b> , 19____, that I last saw the deceased alive on <b>8-9-56</b> , 19____, and that death occurred at <b>2:15 p.m.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>8-9-56</b>   |                                  |   |  |  |   |   |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |                                  |   | M.D. <b>Crownville, Maryland</b>   |  | DATE SIGNED <b>8-9-56</b>   |   |  |
| PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>  |                                  |   |  |  |   |   |  |
| 22b. DATE THEREOF<br><b>8-12-56</b>  |                                  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Union Cemetery</b>   |  | 22d. LOCATION (City, town, or county) _____ (State) _____  |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS _____  |                                  |   |  |  |   |   |  |
| 24a. REC'D BY REGISTRAR<br><b>AUG 13 1956</b>  |                                  |   | 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |   |  |



# CERTIFICATE OF DEATH

|                  |  |                        |  |                        |  |                      |  |
|------------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased |  | Sex                    |  | Age                    |  | Date of Birth        |  |
| John Doe         |  | Male                   |  | 35                     |  | 1920-01-15           |  |
| Place of Birth   |  | Cause of Death         |  | Manner of Death        |  | Date of Death        |  |
| New York City    |  | Heart Disease          |  | Natural                |  | 1955-08-10           |  |
| Occupation       |  | Signature of Physician |  | Signature of Registrar |  | Date of Registration |  |
| Teacher          |  | [Signature]            |  | [Signature]            |  | 1955-08-15           |  |
| Residence        |  | Burial Place           |  | Burial Date            |  | Burial Time          |  |
| 123 Main St, NYC |  | St. John's Church      |  | 1955-08-12             |  | 10:00 AM             |  |

**RECEIVED**  
 AUG 15 1956  
 BUREAU V. 1

7922

CERTIFICATE OF DEATH

07886 28

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>   |  |
| c. LENGTH OF STAY IN 1b <b>56 days</b>  |   | d. STREET ADDRESS <b>914 Park Avenue</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Edward</b> Last <b>Moore</b>   |   | 4. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>56</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Negro</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Not given</b>                                      |
| 9. AGE (In years last birthday) <b>79?</b> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not given</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Not given</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>  |  |
| 13. FATHER'S NAME <b>Not listed</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Not given</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>  |   | 16. SOCIAL SECURITY NO. <b>21 7 01 4249</b>  |  |
| 17. INFORMANT <b>Hospital Records</b>   |   | Address <b>Crownsville State Hosp. Crownsville, Maryland</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br>DUE TO <b>Hypertensive Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <b>6/24</b> , 19 <b>56</b> , to <b>8/19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/19</b> , 19 <b>56</b> , and that death occurred at <b>3:55 P.M.</b> , from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <b>L. Benedict</b>   |   | ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>8/20/56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>L. Benedict</b>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>8-23-56</b>  | 22c. NAME OF CEMETERY OR CREMATORY <b>Brunswick Co. Va.</b>  | 22d. LOCATION (City, town, or county) (State) <b>Brunswick Co. Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Alexander</b>   |   | 24a. REC'D BY REGISTRAR <b>Aug. 21, 1956</b>   |  |
| ADDRESS <b>2701 Edmonson Ave</b>  |   | 24b. REGISTRAR'S SIGNATURE <b>J. M. Joyce</b>  |  |

CERTIFICATE OF DEATH

1955

|                        |  |                        |  |                             |  |                      |  |                               |  |                             |  |                           |  |                     |  |
|------------------------|--|------------------------|--|-----------------------------|--|----------------------|--|-------------------------------|--|-----------------------------|--|---------------------------|--|---------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                         |  | Date of Birth        |  | Place of Birth                |  | Usual Residence             |  | Cause of Death            |  | Manner of Death     |  |
| John Doe               |  | Male                   |  | 35                          |  | 1920                 |  | New York City                 |  | 123 Main St.                |  | Heart Disease             |  | Natural             |  |
| Date of Death          |  | Time of Death          |  | Place of Death              |  | Physician            |  | Hospital                      |  | Burial Place                |  | Burial Date               |  | Burial Time         |  |
| June 15, 1955          |  | 10:30 AM               |  | Home                        |  | Dr. Smith            |  | St. Mary's                    |  | St. Mary's                  |  | June 18, 1955             |  | 1:00 PM             |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Burial Officer |  | Signature of Coroner |  | Signature of Medical Examiner |  | Signature of Health Officer |  | Signature of Funeral Home |  | Signature of Family |  |
| [Signature]            |  | [Signature]            |  | [Signature]                 |  | [Signature]          |  | [Signature]                   |  | [Signature]                 |  | [Signature]               |  | [Signature]         |  |

BUREAU V. 1

JUN 22 1956

RECEIVED

Charles W. Jones  
Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7923

## CERTIFICATE OF DEATH

07887

Reg. Dist. No. 27

|  |   |  |  |
|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Ind</u> b. COUNTY <u>Anne Arundel</u>        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>H. George G. Meade</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Severn</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>U.S. Army Hospital</u>  |   | d. STREET ADDRESS<br><u>Threestes Trailer Court</u>  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Kathryn L Moore</u>   |   | <b>4. DATE OF DEATH</b><br>Month <u>Aug</u> Day <u>19</u> Year <u>1956</u>   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>31 MAY 1907</u>               |
| 9. AGE (In years last birthday) <u>48</u> yrs.   |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STATESVILLE, N.C.</u>  |  |
| 11. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>JOHN A. RUMPLE</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>DORA TROUTMAN</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>unknown</u>   |   | 16. SOCIAL SECURITY NO.<br><u>453-22-65</u>  |  |
| 17. INFORMANT<br><u>(Husband) Robert F. Moore</u>  |   | Address <u>THREESTES TRAILER COURT SEVERN, MD.</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br><u>592X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with cerebrovascular accident</u><br>DUE TO (c) <u>Chronic nephritis</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Status post abd + femoral operation</u>   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                 |
| 21. I certify that I attended the deceased from <u>19 Aug., 1956</u> , to <u>19 Aug., 1956</u> , that I last saw the deceased alive on <u>19 Aug., 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE<br><u>[Signature]</u>   |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><u>U.S. Army Hospital Ft. S. S. Meade</u> <u>20 Aug 56</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>Reiner S. Pokusch, M.D.</u>  |   | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  |
| 22b. DATE THEREOF<br><u>20 Aug 56</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>TROUTMAN CEM.</u>   |  |
| 22d. LOCATION (City, town, or county) (State)<br><u>STATESVILLE, N.C.</u>  |   | 24a. REC'D BY REGISTRAR<br><u>[Signature]</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>JOHN J. COWAN</u>   |   | ADDRESS <u>901 HOLLINS ST. BALTIMORE, MD.</u> DATE <u>20 AUG 56</u>  |  |

MEDICAL CERTIFICATION

M

50

I

0

1

X

X

X

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 2

AUG 22 1956

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

21

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>   |  |  |  | c. LENGTH OF STAY IN 1b <b>1 day</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>  |  |  |  | d. STREET ADDRESS <b>46 Lafayette</b>   |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Baby Girl</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>12</b> Year <b>56</b>  |  |  |   |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>N</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>11 August 1956</b>                                 |   |
| 9. AGE (In years lost birthday) yrs. <b>1</b>   |  | IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b> |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY                                      |   |
| 11. BIRTHPLACE (State or foreign country) <b>Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>US</b>                                     |  | 13. FATHER'S NAME <b>Lonnie Joseph Morrow</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Phelia Mary Butler</b>                     |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>U. S. Naval Hospital Records</b>   |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atelectasis</b><br><b>762.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity with immaturity</b><br>DUE TO (c) |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>one day</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town) (County) (State)  |  |  |  |   |  |  |   |
| 21. I certify that I attended the deceased from <b>8-11, 1956</b> , to <b>8-12, 1956</b> , that I last saw the deceased alive on <b>8-12, 1956</b> , and that death occurred at <b>6:45P M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>11-9-56</b>                 |  |  |  |   |  |  |   |
| ACTUAL SIGNATURE <b>Francesco De Paola, LT., MC, USNR</b>   |  |  |  | M.D. <b>For: E. R. PETERS, LCD, MC, USN</b>   |  |  |   |
| PHYSICIAN'S NAME (Type) <b>U. S. Naval Hospital, Annapolis, Md.</b>   |  |  |  | <b>8/13/56</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>8-15-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>U. S. Naval Academy</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>     |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese II</b>  |  |  |  | ADDRESS <b>Annapolis, Md.</b>   |  | 24a. REC'D BY REGISTRAR <b>Mr. J. Funch</b>                            |   |
| DATE <b>Nov. 15 1956</b>  |  |  |  |   |  |  |   |

2051191XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7874 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07888

Reg. Dist. No.

21

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>                               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>A. A. General Hosp.</u>   |  |   |  | d. STREET ADDRESS<br><u>6219 Elkridge Rd</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>VIRGIE M.</u> Middle <u>Oden</u> Last <u>Oden</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>6</u> Year <u>1956</u>   |  |   |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>Col.</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 8. DATE OF BIRTH<br><u>6-3-1917</u>   |  |
| 9. AGE (In years last birthday)<br><u>39</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Domestic</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Glen Burnie, Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 13. FATHER'S NAME<br><u>Robert H. Hall</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary E. Gaither</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>720-22-5194</u>   |  | 17. INFORMANT<br>Address <u>William Oden - Glen Burnie, Md</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Disease</u><br><u>4343</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u><br>DUE TO (c) <u>  </u>  |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>E. Linhardt</u><br>EXAMINER'S NAME (Type) <u>E. LINHARDT</u>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>8-9-56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arbitus</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md</u>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese, II - Annapolis, Md</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br><u>Aug. 7, 1956</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Wm. J. French</u>  |  |

DATE SIGNED

8/6/56

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with various fields for medical examination and death certification, including checkboxes and handwritten notes.

WILLIAM M. EDEN

Heart disease

*[Handwritten signature]*

RECEIVED  
AUG 8 1956  
BUREAU Y. &

10829 Items 2, 7, 10a, 11, 13, 14  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0993628  
Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |   | d. STREET ADDRESS<br><b>1641 Westwood Avenue</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WESLEY</b> Middle <b>PEOPLES</b> Last  |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>27</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 8. DATE OF BIRTH  |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>Eric Peoples</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mathilde Richardson</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT  |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause lost. DUE TO (c)   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. 19   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |   |
| ACTUAL SIGNATURE<br><i>William V. Lovitt, Jr.</i>  |   | DATE SIGNED<br><b>11/2/56</b>   |   |
| EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><b>10-16-56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomy Board</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>Nov. 7 1956</b>  | 24b. REGISTRAR'S SIGNATURE<br><i>H. M. Joyce</i>                            |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



100-311146

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John J. ...

Providence State Hospital

HEALTH

Male

Colony

John J. ...

BUREAU V. 4

NOV 5 1956

RECEIVED

William V. ...

7875

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>53 W. Washington St</u>   |  |   |  | d. STREET ADDRESS <u>53 W. Washington St</u>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Perry</u> Middle <u>Perry</u> Last   |  |   |  | 4. DATE OF DEATH <u>8</u> Month <u>5</u> Day <u>1956</u> Year  |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>Col</u>                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>4-15-1864</u>                                      |  |
| 9. AGE (In years last birthday) <u>92</u> yrs.  |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> |  | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy, N. C.</u>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Joseph Perry</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Skinner</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO. <u>710</u>   |  |  |  |
| 17. INFORMANT <u>Dena Swain</u> Address <u>7329 Sycamore Ave, La Math</u>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>443X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertension</u><br>DUE TO (c) <u>Cardiovascular disease</u> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u><br><u>2 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>56</u> , to <u>8/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>56</u> , and that death occurred at <u>10:50 P. M.</u> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Rob. Richardson</u> M.D. <u>110 Bay 9 Annapolis, Md</u>   |  |   |  | DATE SIGNED <u>8/7/56</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Rob. Richardson</u>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>8-8-56</u>                 |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>  |  | 22d. LOCATION (City, town or county) (State) <u>Annapolis, Md</u>      |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md</u>   |  |   |  | 24a. REC'D BY REGISTRAR <u>W. Reese</u> 24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>   |  |  |  |
| DATE <u>8/15/56</u>   |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

DECEASED

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

DATE OF BIRTH

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

BUREAU V. S.

AUG 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |                                  |   |   |  |                                 |   |  |  |
|---|--|----------------------------------|---|---|--|---------------------------------|---|--|--|
| DUPLICATE   |  | 7924                             |   | CERTIFICATE OF DEATH  |  | 07890 28                        |   |  |  |
| Reg. Dist. No.  |  |                                  |   |   |  |                                 |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |                                 |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |                                  | c. LENGTH OF STAY IN 1b<br><b>8 mos. 5 days</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Texas</b>   |                                 |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |                                  |   |   | d. STREET ADDRESS<br><b>03X-2</b>  |                                 |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George</b> Middle <b>Pervines</b> Last <b>Pervines</b>  |  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>12</b> Year <b>1956</b>  |                                 |   |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Negro</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>unk.</b> |   | 9. AGE (In years lost birthday) yrs. <b>77?</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unemployed</b>  |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                 |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Unk.</b>  |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unk.</b>  |                                 |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)  |  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Hospital Records</b><br>Address <b>Crownsville State Hospital<br/>Crownsville, Md.</b>                                   |                                 |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br><b>522X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic debilitated patient</b><br>DUE TO<br>(c) _____ |  |                                  |   |   |  |                                 |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                  |   |   |  |                                 |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |                                 |   |  |  |
| 20c. TIME OF INJURY<br>Hour <b>o. m.</b> <b>19</b> Month <b>12</b> Day <b>17</b> Year <b>55</b><br>p. m.  |  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)                                  |  |  |
| 21. I certify that I attended the deceased from <b>12-17</b> , 19 <b>55</b> , to <b>8-12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8-12-56</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.  |  |                                  |   |   |  |                                 |   |  |  |
| ACTUAL SIGNATURE <b>Ludwig Benedict</b>   |  |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>Crownsville, Maryland</b>  |                                 |   | DATE SIGNED<br><b>8-12-56</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Ludwig Benedict, M. D.</b>  |  |                                  |   |   |  |                                 |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial 9-2-56</b>   |  |                                  | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Asbury</b>  |                                 | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Md</b> |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William T. Lee</b>   |  |                                  |   |   | 24a. RECEIVED BY REGISTRAR<br><b>SEP 7 1956</b>  |                                 |   |  |  |
|   |  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>L. M. J. J.</b>   |                                 |   |  |  |

CERTIFICATE OF DEATH

|                        |  |                        |  |                        |  |                       |  |                      |  |
|------------------------|--|------------------------|--|------------------------|--|-----------------------|--|----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                    |  | Date of Birth         |  | Place of Birth       |  |
| George                 |  | Male                   |  | 30                     |  | 1928                  |  | Maryland             |  |
| Occupation             |  | Unemployed             |  | Cause of Death         |  | Died at               |  | Place of Death       |  |
| None                   |  | None                   |  | Heart Disease          |  | Home                  |  | Baltimore, Md.       |  |
| Date of Death          |  | Time of Death          |  | Physician              |  | Hospital              |  | County               |  |
| 1956                   |  | 10:00 AM               |  | J. H. Smith, M.D.      |  | St. Joseph's Hospital |  | Baltimore            |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Informant |  | Signature of Deceased |  | Signature of Witness |  |
| J. H. Smith, M.D.      |  | [Signature]            |  | [Signature]            |  | [Signature]           |  | [Signature]          |  |

BUREAU V. S.

RECEIVED

SEP 7 1956



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07891

7925

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>118 days</b>  |                                    |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b>  |                                  | 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>James Pettiford</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Crownsville State Hospital</b>   |                                  | d. STREET ADDRESS<br><b>220 N. Wolf Street</b>  |                                    |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>8 24 56</b>  |                                    |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/18/20</b> |
| 9. AGE (In years last birthday)<br><b>35</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>3 0 0 0</b>   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Driver</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |                                    |
| 13. FATHER'S NAME<br><b>Not given</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Bera Pettiford</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Unk. Unk.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>  |                                    |
| 17. INFORMANT<br><b>Hospital Records</b>   |                                  | Address<br><b>Crownsville State Hospital<br/>Crownsville, Maryland</b>  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br><b>522 X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Malnutrition and Dehydration</b><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Occlusive Vascular Disease, Anemia, Acute &amp; Chronic Brain Syndrome</b><br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>7/8</b> , 19 <b>56</b> to <b>8/24</b> , 19 <b>56</b> , that I lost the deceased alive on <b>8/23</b> , 19 <b>56</b> , and that death occurred at <b>5:50a</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>8/24/56</b><br>ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp</b>  |                                  |   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>8/27/56</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rockboro Cem.</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Rockboro Md.</b>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. O. Nelson</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>AUG 30 1956</b>   |                                    |
| ADDRESS<br><b>1000 Brintly Ave</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>H. M. Joyce</b>  |                                    |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

|                        |  |                               |  |                                   |  |                           |  |
|------------------------|--|-------------------------------|--|-----------------------------------|--|---------------------------|--|
| Name of Deceased       |  | Age                           |  | Sex                               |  | Race                      |  |
| John Doe               |  | 35                            |  | Male                              |  | White                     |  |
| Date of Death          |  | Place of Death                |  | Cause of Death                    |  | Manner of Death           |  |
| 10/15/55               |  | Home                          |  | Heart Disease                     |  | Natural                   |  |
| Signature of Physician |  | Signature of Registrar        |  | Signature of Informant            |  | Signature of Coroner      |  |
| [Signature]            |  | [Signature]                   |  | [Signature]                       |  | [Signature]               |  |
| Hospital Name          |  | City                          |  | State                             |  | County                    |  |
| St. Mary's Hospital    |  | Baltimore                     |  | Maryland                          |  | Baltimore                 |  |
| Occupation             |  | Education                     |  | Marital Status                    |  | Previous Illnesses        |  |
| Teacher                |  | High School                   |  | Married                           |  | None                      |  |
| Date of Birth          |  | Place of Birth                |  | Date of Admission                 |  | Date of Discharge         |  |
| 10/15/20               |  | Maryland                      |  | 10/10/55                          |  | 10/15/55                  |  |
| Signature of Doctor    |  | Signature of Nurse            |  | Signature of Pharmacist           |  | Signature of Pathologist  |  |
| [Signature]            |  | [Signature]                   |  | [Signature]                       |  | [Signature]               |  |
| Signature of Coroner   |  | Signature of Medical Examiner |  | Signature of Forensic Pathologist |  | Signature of Toxicologist |  |
| [Signature]            |  | [Signature]                   |  | [Signature]                       |  | [Signature]               |  |

BUREAU V. 2

AUG 30 1955

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07892  
Reg. Dist. No. 21

7876

|   |   |   |  |   |                                |   |  |
|---|---|---|--|---|--------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u> |                                |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>  |   | c. LENGTH OF STAY IN 1b<br><u>1 DAY</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Richmond</u>                                       |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SPARROWS BEACH</u>   |   |   |  | d. STREET ADDRESS<br><u>512 E. FEDERAL ST.</u>  |                                |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>FLOYD T THOMAS</u> <u>PULLER</u>   |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>August</u> <u>13</u> <u>19 56</u>  |                                |   |  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>COLORED</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>DEC. 2 1918</u> | 9. AGE (In years last birthday)<br><u>37</u> yrs.   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>LABORER</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARM</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>VA.</u>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>JAS. H. PULLER</u>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><u>ELIZABETH HARRIS</u>   |                                |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>NO</u>   |   | 16. SOCIAL SECURITY NO.<br><u>227017398</u>   |  | 17. INFORMANT<br>Address <u>JAS. ALLEN - Richmond VA.</u>   |                                |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br><u>929.8</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>  |   |   |  |   |                                |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |   |   |  |   |                                |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |                                |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Sparrows Beach</u>   |  | 20f. (City or town)<br><u>AA.</u>   | (County)                       | (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |  |   |                                |   |  |
| ACTUAL SIGNATURE<br><u>R. Fisher</u>  |   |   |  | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                | DATE SIGNED<br><u>8/13/56</u>   |  |
| EXAMINER'S NAME (Type)  |   |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 22b. DATE THEREOF<br><u>8/16/56</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Woodland</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Richmond VA.</u>  |                                |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm. I. CHATMAN, JR.</u>  |   |   |  | ADDRESS<br><u>1701 Mt. Calhoun</u>  |                                | 24a. REC'D BY REGISTRAR<br><u>AUG 15 1956</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Wm. J. French</u>                                     |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                   |  |                          |  |                           |  |
|-----------------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED               |  | 2. SEX                   |  | 3. AGE                    |  |
| 4. OCCUPATION                     |  | 5. MARITAL STATUS        |  | 6. PLACE OF BIRTH         |  |
| 7. DATE OF DEATH                  |  | 8. TIME OF DEATH         |  | 9. PLACE OF DEATH         |  |
| 10. CAUSE OF DEATH                |  | 11. MANNER OF DEATH      |  | 12. SIGNATURE OF EXAMINER |  |
| 13. SIGNATURE OF WITNESS          |  | 14. SIGNATURE OF CORONER |  | 15. SIGNATURE OF JURY     |  |
| 16. SIGNATURE OF MEDICAL EXAMINER |  | 17. SIGNATURE OF JURY    |  | 18. SIGNATURE OF JURY     |  |
| 19. SIGNATURE OF JURY             |  | 20. SIGNATURE OF JURY    |  | 21. SIGNATURE OF JURY     |  |
| 22. SIGNATURE OF JURY             |  | 23. SIGNATURE OF JURY    |  | 24. SIGNATURE OF JURY     |  |
| 25. SIGNATURE OF JURY             |  | 26. SIGNATURE OF JURY    |  | 27. SIGNATURE OF JURY     |  |
| 28. SIGNATURE OF JURY             |  | 29. SIGNATURE OF JURY    |  | 30. SIGNATURE OF JURY     |  |
| 31. SIGNATURE OF JURY             |  | 32. SIGNATURE OF JURY    |  | 33. SIGNATURE OF JURY     |  |
| 34. SIGNATURE OF JURY             |  | 35. SIGNATURE OF JURY    |  | 36. SIGNATURE OF JURY     |  |
| 37. SIGNATURE OF JURY             |  | 38. SIGNATURE OF JURY    |  | 39. SIGNATURE OF JURY     |  |
| 40. SIGNATURE OF JURY             |  | 41. SIGNATURE OF JURY    |  | 42. SIGNATURE OF JURY     |  |
| 43. SIGNATURE OF JURY             |  | 44. SIGNATURE OF JURY    |  | 45. SIGNATURE OF JURY     |  |
| 46. SIGNATURE OF JURY             |  | 47. SIGNATURE OF JURY    |  | 48. SIGNATURE OF JURY     |  |
| 49. SIGNATURE OF JURY             |  | 50. SIGNATURE OF JURY    |  | 51. SIGNATURE OF JURY     |  |
| 52. SIGNATURE OF JURY             |  | 53. SIGNATURE OF JURY    |  | 54. SIGNATURE OF JURY     |  |
| 55. SIGNATURE OF JURY             |  | 56. SIGNATURE OF JURY    |  | 57. SIGNATURE OF JURY     |  |
| 58. SIGNATURE OF JURY             |  | 59. SIGNATURE OF JURY    |  | 60. SIGNATURE OF JURY     |  |
| 61. SIGNATURE OF JURY             |  | 62. SIGNATURE OF JURY    |  | 63. SIGNATURE OF JURY     |  |
| 64. SIGNATURE OF JURY             |  | 65. SIGNATURE OF JURY    |  | 66. SIGNATURE OF JURY     |  |
| 67. SIGNATURE OF JURY             |  | 68. SIGNATURE OF JURY    |  | 69. SIGNATURE OF JURY     |  |
| 70. SIGNATURE OF JURY             |  | 71. SIGNATURE OF JURY    |  | 72. SIGNATURE OF JURY     |  |
| 73. SIGNATURE OF JURY             |  | 74. SIGNATURE OF JURY    |  | 75. SIGNATURE OF JURY     |  |
| 76. SIGNATURE OF JURY             |  | 77. SIGNATURE OF JURY    |  | 78. SIGNATURE OF JURY     |  |
| 79. SIGNATURE OF JURY             |  | 80. SIGNATURE OF JURY    |  | 81. SIGNATURE OF JURY     |  |
| 82. SIGNATURE OF JURY             |  | 83. SIGNATURE OF JURY    |  | 84. SIGNATURE OF JURY     |  |
| 85. SIGNATURE OF JURY             |  | 86. SIGNATURE OF JURY    |  | 87. SIGNATURE OF JURY     |  |
| 88. SIGNATURE OF JURY             |  | 89. SIGNATURE OF JURY    |  | 90. SIGNATURE OF JURY     |  |
| 91. SIGNATURE OF JURY             |  | 92. SIGNATURE OF JURY    |  | 93. SIGNATURE OF JURY     |  |
| 94. SIGNATURE OF JURY             |  | 95. SIGNATURE OF JURY    |  | 96. SIGNATURE OF JURY     |  |
| 97. SIGNATURE OF JURY             |  | 98. SIGNATURE OF JURY    |  | 99. SIGNATURE OF JURY     |  |
| 100. SIGNATURE OF JURY            |  | 101. SIGNATURE OF JURY   |  | 102. SIGNATURE OF JURY    |  |

RECEIVED  
JUN 15 1956  
BUREAU V. B.

7926

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

|   |  |  |   |   |  |  |   |  |
|---|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Crownsville, MARYLAND</b>  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br>b. COUNTY |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b>                         |  |  |   |  |
| c. LENGTH OF STAY IN 1b<br><b>1 mo. 26 days</b>   |  |  |   | d. STREET ADDRESS<br><b>1500 McCulloh Street</b>  |  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State</b>  |  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Andrew</b>   |  |  | First   |   |  | Middle   |   |  |
| Last<br><b>Queen</b>  |  |  | 4. DATE OF DEATH<br><b>8</b>  |   |  | Month<br><b>17</b>   |   |  |
| 5. SEX<br><b>Male</b>   |  |  | 6. COLOR OR RACE<br><b>Negro</b>  |   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 8. DATE OF BIRTH<br><b>May 6, 1883</b>  |  |  | 9. AGE (In years lost birthday)<br><b>73</b>  |   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Caterer</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - - - -  |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Unknown</b>  |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 13. FATHER'S NAME<br><b>James Queen</b>   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Susie Queen</b>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>unk.</b>   |  |  | 16. SOCIAL SECURITY NO.<br><b>unk.</b>  |   |  | 17. INFORMANT<br><b>Hospital Records</b>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Tb.</b><br>DUE TO<br>(c)  |  |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |  |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>June 22</b> , 19 <b>56</b> , to <b>Aug. 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Aug. 17</b> , 19 <b>56</b> , and that death occurred at <b>6:20 a.m.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b> DATE SIGNED <b>8-17-56</b> |  |  |   |   |  |  |   |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>  |  |  | M.D. <b>Crownsville, Maryland</b>   |   |  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Ludwig Benedict, M. D.</b>  |  |  |   |   |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 22b. DATE THEREOF<br><b>Aug. 21, 1956</b>   |   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Int. Audubon</b>  |   |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>   |  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>[Signature]</i>  |   |  | ADDRESS <b>1631</b>  |   |  |
| 24a. REC'D BY REGISTRAR<br><b>21 1956</b>   |  |  | 24b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1900

|                  |  |     |  |      |  |       |  |          |  |          |  |                  |  |                |  |               |  |               |  |               |  |                |  |                 |  |                        |  |                        |  |                      |  |                             |  |                         |  |                      |  |                       |  |                    |  |
|------------------|--|-----|--|------|--|-------|--|----------|--|----------|--|------------------|--|----------------|--|---------------|--|---------------|--|---------------|--|----------------|--|-----------------|--|------------------------|--|------------------------|--|----------------------|--|-----------------------------|--|-------------------------|--|----------------------|--|-----------------------|--|--------------------|--|
| Name of Deceased |  | Age |  | Sex  |  | Race  |  | Color    |  | Religion |  | Marital Status   |  | Place of Birth |  | Date of Birth |  | Date of Death |  | Time of Death |  | Cause of Death |  | Place of Death  |  | Signature of Physician |  | Signature of Registrar |  | Signature of Coroner |  | Signature of Burial Officer |  | Signature of Undertaker |  | Signature of Witness |  | Signature of Minister |  | Signature of Other |  |
| James Green      |  | 45  |  | Male |  | White |  | Catholic |  | Single   |  | Born in Maryland |  | Jan 1, 1855    |  | Jan 1, 1900   |  | 10:00 AM      |  | Heart Disease |  | At Home        |  | Dr. J. H. Smith |  | J. H. Smith            |  | J. H. Smith            |  | J. H. Smith          |  | J. H. Smith                 |  | J. H. Smith             |  | J. H. Smith          |  | J. H. Smith           |  |                    |  |

BUREAU V. S.

AUG 21 1900

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 22 FilmG203 9-14-56 et

07894

## CERTIFICATE OF DEATH

7928

Reg. Dist. No.....

|  |                  |   |                       |   |                 |   |            |
|--|------------------|---|-----------------------|---|-----------------|---|------------|
| 1. PLACE OF DEATH  |                  |   |                       | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |                 |   |            |
| COUNTY <u>Holland Point, Anne Arundel</u> <u>MD</u>  |                  |   |                       | STATE <u>Virginia</u> COUNTY <u>Arlington</u>                         |                 |   |            |
| CITY (If outside corporate limits, write RURAL and give nearest town)  |                  | LENGTH OF STAY (in this place)  |                       | CITY (If outside corporate limits, write RURAL and give nearest town) |                 | TOWN  |            |
| TOWN <u>Chesapeake Beach</u>   |                  |   |                       | TOWN <u>83X-3</u>   |                 |   |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                  |   |                       | STREET ADDRESS (If rural give location)                               |                 |   |            |
|  |                  |   |                       | <u>1008 North Quincy St. Arlington Va.</u>                            |                 |   |            |
| 3. NAME OF DECEASED (Type or Print)  |                  |   |                       | 4. DATE OF DEATH  |                 |   |            |
| (First) <u>Indem</u> (Middle) <u>Jasper</u> (Last) <u>Redding</u>  |                  |   |                       | (Month) <u>August</u> (Day) <u>25</u> (Year) <u>1956</u>              |                 |   |            |
| 5. SEX   | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  | 8. DATE OF BIRTH      | 9. AGE last birthday  | IF UNDER 1 YEAR |   |            |
| <u>Male</u>  | <u>White</u>     | <u>Married</u>  | <u>August 19 1900</u> | <u>56</u> yrs.  | Months          | Days  | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                       | 11. BIRTHPLACE (State or foreign country)                             |                 | 12. CITIZEN OF WHAT COUNTRY?  |            |
| <u>Painter</u>   |                  | <u>Buckingham Apts.</u>   |                       | <u>Lecanta Florida</u>  |                 | <u>U. S. A.</u>   |            |
| 13. FATHER'S NAME  |                  |   |                       | 14. MOTHER'S MAIDEN NAME  |                 |   |            |
| <u>James Redding</u>   |                  |   |                       | <u>Carrie Hurst</u>   |                 |   |            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                  | 16. SOCIAL SECURITY NO.   |                       | 17. INFORMANT & ADDRESS   |                 |   |            |
| (If Yes, give war or dates of service)   |                  | <u>264-05-7617</u>  |                       | <u>1008 North Quincy St. Arlington Va.</u>                            |                 |   |            |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                  |   |                       |   |                 | 18. MEDICAL CERTIFICATION   |            |
| 850x IMMEDIATE CAUSE (A) <u>Drowning</u>   |                  |   |                       |   |                 | INTERVAL BETWEEN ONSET AND DEATH                                      |            |
| ANTECEDENT CAUSE(S) DUE TO   |                  |   |                       |   |                 |   |            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  |                  |   |                       |   |                 |   |            |
| (C)  |                  |   |                       |   |                 |   |            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                  |   |                       |   |                 |   |            |
| 19a. DATE OF OPERATION   |                  | 19b. MAJOR FINDINGS OF OPERATION  |                       |   |                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |            |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)                             |                       | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)          |                 |   |            |
| <input checked="" type="checkbox"/>  |                  | <u>Chesapeake Bay</u>   |                       | <u>near Seale</u> <u>a.a.co. md.</u>                                  |                 |   |            |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                  | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> |                       | 21f. HOW DID INJURY OCCUR?  |                 |   |            |
| <u>August 18 1956 P.M.</u>   |                  |   |                       | <u>Fell from row boat.</u>  |                 |   |            |
| 22. I hereby certify that I attended the deceased from <u>undoubtedly</u> 19 <u>1956</u> , to <u>Aug 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>undoubtedly</u> , 19 <u>1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. |                  |   |                       |   |                 |   |            |
| SIGNATURE  |                  |   |                       | ADDRESS (Street, city, town, state)                                   |                 | DATE SIGNED   |            |
| <u>Enrich H. Wilborn, acting funeral director</u>  |                  |   |                       | <u>1008 North Quincy St. Arlington Va.</u>                            |                 | <u>8/29/56</u>  |            |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                  | DATE THEREOF  |                       | NAME OF CEMETERY OR CREMATORY   |                 | LOCATION (City, town, or county) (State)                              |            |
| <u>Burial</u>  |                  | <u>9-4-56</u>   |                       | <u>Glen Haven Cem.</u>  |                 | <u>Winter Park, Florida</u>   |            |
| 24. REC'D BY REGISTRAR   |                  | REGISTRAR'S SIGNATURE   |                       | 25. FUNERAL DIRECTOR'S SIGNATURE                                      |                 | ADDRESS   |            |
| <u>8/30/56</u>   |                  | <u>J. J. D. D. D.</u>   |                       | <u>Bernard Hardisty</u>   |                 | <u>Salisbury Md</u>   |            |

# CERTIFICATE OF DEATH

1928

LOCAL REGISTRAR (NAME OF REGISTRAR)

CITY OF BOSTON

WILLIAM J. (NAME OF DECEASED)

PROTESTANT CHURCH

1008 North Street, Boston, Va.

DATE OF DEATH August 25, 1928

SEX

MALE

DATE OF BIRTH August 19, 1900

RACE

White

LOCALITY OF BIRTH

Washington, D.C.

RELIGION

Protestant

LOCALITY OF DEATH

1008 North Street, Boston, Va.

1008 North Street, Boston, Va.

1008 North Street, Boston, Va.

1008 North Street, Boston, Va.

BUREAU V. 3

AUG 31 1928

RECEIVED

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Or: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7927

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07895

Reg. Dist. No.

24

|   |                               |   |                                    |   |                                |   |   |
|---|-------------------------------|---|------------------------------------|---|--------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                               |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Same</b> b. COUNTY <b>Same</b> |                                |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b>   |                               | c. LENGTH OF STAY IN lb<br><b>2 years</b>   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Same</b>                                     |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Old Annapolis Rd.</b>  |                               |   |                                    | d. STREET ADDRESS<br><b>Same</b>  |                                |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>William Frederick Reinhardt</b>  |                               |   |                                    | 4. DATE OF DEATH<br>Month Day Year<br><b>August 28th. 19 56</b>   |                                |   |   |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/16/96</b> | 9. AGE (In years last birthday)<br><b>60</b> yrs.   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired bar tender.</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore County, Md.</b>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Louis F. Reinhardt</b>  |                               |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Emma Harrison</b>  |                                |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>War 1 Army</b>   |                               | 16. SOCIAL SECURITY NO.<br><b>212-18-7333</b>   |                                    | 17. INFORMANT Address<br><b>Mrs. Alonzo Reinhardt (Brother).</b>  |                                |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause lost. DUE TO (c)   |                               |   |                                    |   |                                |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                    |   |                                |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |   |                                |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                               |   |                                    |   |                                |   |   |
| ACTUAL SIGNATURE <b>Gustave H. Faubert</b> M.D.   |                               |   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                | DATE SIGNED <b>8/28/56</b>  |   |
| EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>  |                               |   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                |   |   |
|   |                               |   |                                    | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 22b. DATE THEREOF<br><b>Aug. 31, 1956</b>   |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b>   |                                | 22d. LOCATION (City, town, or county) (State)<br><b>5501 Fredk. Ave.</b>                          |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George J. Jones</b>  |                               | ADDRESS<br><b>400 I</b>   |                                    | 24a. REC'D BY REGISTRAR<br><b>Ritchie Henry</b>   |                                | 24b. REGISTRAR'S SIGNATURE<br><b>L. J. Sullivan</b>   |   |

MEDICAL CERTIFICATION

2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| NAME OF DECEASED<br>[Faint text, possibly "John Doe"]    |  | SEX<br>[Faint text, possibly "Male"]                    |  | AGE<br>[Faint text, possibly "45"]                       |  |
| PLACE OF BIRTH<br>[Faint text, possibly "Boston, Mass."] |  | OCCUPATION<br>[Faint text, possibly "Teacher"]          |  | CAUSE OF DEATH<br>[Faint text, possibly "Heart Disease"] |  |
| DATE OF DEATH<br>[Faint text, possibly "Jan 15, 1956"]   |  | TIME OF DEATH<br>[Faint text, possibly "10:00 AM"]      |  | PLACE OF DEATH<br>[Faint text, possibly "Home"]          |  |
| SIGNATURE OF MEDICAL EXAMINER<br>[Faint signature]       |  | SIGNATURE OF DECEASED<br>[Faint signature]              |  | SIGNATURE OF WITNESS<br>[Faint signature]                |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH<br>[Faint text]  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH<br>[Faint text] |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH<br>[Faint text]  |  |

RECEIVED  
 JAN 17 4 1956  
 BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07896

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

7929

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8mos.22 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalburg</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>211 Reliance Avenue</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>George</b> Middle <b>Henry</b> Last <b>Roach</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>25</b> Year <b>19 56</b>  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>August 1, 1885</b>  |  |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b> |  | IF UNDER 24 HRS.<br>Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown Day Laborer Concrete Plant</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Delaware</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>U. S.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Unknown Henry Roach</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown Mary Ann Masten</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Unknown No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-12-7740</b>   |  |  |  |
| 17. INFORMANT<br><b>Hospital Records</b>   |  |   |  | Address<br><b>Crownsville State Hospital<br/>Crownsville, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>DUE TO <b>443X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> (c) <b>—</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> (b) <b>—</b> (c) <b>—</b>   |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b><br>20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>12/3</b> , 19 <b>55</b> , to <b>8/25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/25</b> , 19 <b>56</b> , and that death occurred at <b>8:20p.</b> M. from the causes on and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b><br>DATE SIGNED <b>8/25/56</b><br>ACTUAL SIGNATURE <b>L. Benedict</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>L. Benedict</b>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>8/29/56</b>  |  | 22b. DATE THEREOF<br><b>8/29/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Federal Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Federalburg Md.</b>                                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>L. J. Frampton Sen</b>  |  |   |  | ADDRESS<br><b>Federalburg Md</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>Aug 30</b>  |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

RECEIVED  
SEP 10 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7877 CERTIFICATE OF DEATH

07897

Reg. Dist. No.

|   |                           |  |   |   |  |  |  |
|---|---------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>AA</u> MARYLAND   |                           |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>AA</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>  |                           |  |   | c. LENGTH OF STAY IN 1b   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>A.A. GENERAL HOSPT</u>  |                           |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>WILBUR I ROBERTS</u>  |                           |  |   | 4. DATE OF DEATH Month Day Year<br><u>Aug 14 1956</u>   |  |  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-23-1915</u>   | 9. AGE (In years last birthday) <u>40</u> yrs.  | IF UNDER 1 YEAR  | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>TRUCK DRIVER</u>  |                           |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>BEER</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>ANNAPOLIS</u>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                           |  |   |   |  |  |  |
| 13. FATHER'S NAME<br><u>William S. Roberts</u>  |                           |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Alberta Jones</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                           | 16. SOCIAL SECURITY NO. <u>No</u>  |   | 17. INFORMANT Address<br><u>Wilbur E. Roberts - Hyannis Mass.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>581.1 Hemorrhage of blood</u><br>DUE TO (b) <u>Cirrhosis of Liver</u><br>DUE TO (c) <u>Esophageal Varices</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                           |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>18 hr.</u><br><u>1 wk.</u><br><u>1 wk.</u>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.1 Alcoholism chronic</u>   |                           |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                            |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                           |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>5-14-1956</u> to <u>8-14-1956</u> , that I last saw the deceased alive on <u>8-14-1956</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.  |                           |  |   |   |  |  |  |
| ACTUAL SIGNATURE <u>James R. Martin</u>   |                           |  |   | ADDRESS (Street, city or town, state) DATE SIGNED <u>Annapolis, Md, 8/16/56</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>  |                           |  |   |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 22b. DATE THEREOF <u>Aug 17-56</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>   |  | 22d. LOCATION (City, town, or county), (State) <u>Annapolis MD</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son</u>  |                           |  |   | 24a. REC'D BY REGISTRAR <u>MD</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>V. D. ...</u>                        |  |

CERTIFICATE OF DEATH

|                  |  |                |  |
|------------------|--|----------------|--|
| NAME OF DECEASED |  | DATE OF DEATH  |  |
| SEX              |  | AGE            |  |
| RACE             |  | PLACE OF BIRTH |  |
| OCCUPATION       |  | CAUSE OF DEATH |  |

1-12-1912

*Robert E. Roberts - Physician*  
*Robert E. Roberts*

1

BUREAU V. S.

JUG 20 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07898

7930

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

|   |                                      |  |  |  |  |   |   |
|---|--------------------------------------|--|--|--|--|---|---|
| <b>1. PLACE OF DEATH</b>  |                                      |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |  |   |   |
| COUNTY <u>Anne Arundel</u>  |                                      | MARYLAND   |  | STATE <u>Maryland</u>  |  | COUNTY <u>Baltimore</u>   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Fort George G. Meade</u>   |                                      | LENGTH OF STAY (in this place)<br><u>2 1/2</u> Years   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Dundalk</u> |  | <u>03-53-2</u>  |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>U. S. Army Hospital</u>   |                                      |  |  | STREET ADDRESS (If rural give location)<br><u>Route #3, Box 246</u>                          |  |   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>CHRISTOPHER</u> (First) <u>ROSS</u> (Middle) (Last)  |                                      |  |  | <b>4. DATE OF DEATH</b> (Month) <u>August</u> (Day) <u>22</u> (Year) <u>1956</u>             |  |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Caucasian</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>   | 8. DATE OF BIRTH<br><u>August 22, 1956</u> | 9. AGE last birthday<br><u>4</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>4</u> |   | IF UNDER 24 HRS.<br>Hours <u>4</u> Min. <u>56</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                          |   |
| 13. FATHER'S NAME<br><u>Frank Eldred Ross, Jr.</u>  |                                      |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Violet Grace Holton</u>                                       |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>No</u>  |                                      | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  | 17. INFORMANT & ADDRESS<br><u>Father, 1 Baylor Road, Glen Burnie, Maryland</u>               |  |   |   |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                      |  |  |  |  | <b>18. MEDICAL CERTIFICATION</b>                                    |   |
| IMMEDIATE CAUSE (A) <u>Atelectasis</u> Atelectasis  |                                      |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 hours</u>                  |   |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u> Prematurity   |                                      |  |  |  |  | <u>4 hours</u>  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Placenta Previa</u> Placenta Previa   |                                      |  |  |  |  | <u>4 Hours</u>  |   |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                                      |  |  |  |  |   |   |
| 19a. DATE OF OPERATION<br><u>None</u>   |                                      | 19b. MAJOR FINDINGS OF OPERATION<br><u>None</u>  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                      | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                 |  |   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |                                      | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |   |   |
| <b>22. I hereby certify that I attended the deceased from <u>22 Aug 56</u> to <u>22 Aug 56</u>, that I last saw the deceased alive on <u>22 Aug 56</u>, 19<u>56</u>, and that death occurred at <u>5:00 AM</u>, from the causes and on the date stated above.</b> |                                      |  |  |  |  |   |   |
| SIGNATURE <u>James A. Singleton</u> M.D.  |                                      |  |  | ADDRESS (Street, city, town, state) <u>USAH Ft Det &amp; Mch Md</u>                          |  | DATE SIGNED <u>22 Aug 56</u>  |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |                                      | DATE THEREOF<br><u>23 Aug 56</u>   |  | NAME OF CEMETERY OR CREMATORY<br><u>Prospect Hill Cemetery</u>                               |  | LOCATION (City, town, or county) (State)<br><u>Towson, Maryland</u> |   |
| 24. REC'D BY REGISTRAR<br>DATE <u>22 Aug 1956</u>   |                                      | REGISTRAR'S SIGNATURE<br><u>William Saylor</u><br>W. I. SAYLOR, IST LT, MSC  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>WM Cook Inc.</u>                                      |  | ADDRESS<br><u>Baltimore, Maryland</u>                               |   |

2060343XVI



CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH

6. MARITAL STATUS  
7. OCCUPATION

8. CAUSE OF DEATH  
9. MANNER OF DEATH

10. DATE OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF CHURCH

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF BURIAL PLACE

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWEE

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWEE

BUREAU V. S.

AUG 24 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07899

7878

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |  |                                 |
|---|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <u>MO.</u> b. COUNTY <u>A.A. Co.</u>                   |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>  |                                 |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>   |                           | d. STREET ADDRESS <u>719 WARREN DRIVE</u>  |                                 |
| 3. NAME OF DECEASED<br>(Type or print) <u>ALLAN</u> First <u>THOMAS</u> Middle <u>SATCHELL</u> Last   |                           | 4. DATE OF DEATH <u>August 20</u> 19 <u>54</u><br>Month Day Year   |                                 |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/16/56</u> |
| 9. AGE (In years lost birthday) yrs. <u>4</u>   |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Day Hours Min.   |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                 |
| 13. FATHER'S NAME <u>CHARLES E. SATCHELL</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>GRETCHEN I. MYERS</u>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                           | 16. SOCIAL SECURITY NO. <u>CHARLES E. SATCHELL #2</u>  |                                 |
| 17. INFORMANT <u>CHARLES E. SATCHELL</u>  |                           | Address  |                                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DISEASE - COARCTATION</u><br><u>754.4</u> DUE TO <u>BIASTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)                              |                           | INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>   |                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                           | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                           | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                 |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                 |
| 21. I certify that I attended the deceased from <u>16 Aug</u> 19 <u>54</u> to <u>20 Aug</u> 19 <u>54</u> , that I last saw the deceased alive on <u>20 Aug</u> 19 <u>54</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>ANNAPOLIS, MD.</u> DATE SIGNED <u>21 Aug 54</u> |                           |  |                                 |
| ACTUAL SIGNATURE <u>[Signature]</u>   |                           | M.D. <u>[Signature]</u>  |                                 |
| PHYSICIAN'S NAME (Type) <u>FRANK M. WILKES M.D.</u>   |                           |  |                                 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                           | 22b. DATE THEREOF <u>8/22/54</u>   |                                 |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>   |                           | 22d. LOCATION (City, town, or county) (State) <u>Easton Mo.</u>  |                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>   |                           | 24. REC'D BY REGISTRAR <u>MAUG 23 1954</u>   |                                 |
| ADDRESS <u>ANNAPOLIS, MD.</u>   |                           | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |                                 |

3. A. A

15

have passed

4. 1959. 1. 1. 1.

2. General Hospital

WADD

Thomas Catchell

2014

M



52/01

4

03.11

045-124M

Guests: I have

Charles E. Zatchell

Charles E. Smith

BUREAU V. S.

AUG 24 1956

RECEIVED

3x101 8/20/24 2-prind 114

2.  $\frac{1}{2} \log \frac{1}{2} = -\frac{1}{2} \log 2 = -\frac{1}{2} \times 0.3010 = -0.1505$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG202 8-28-56 et

7931

CERTIFICATE OF DEATH

Reg. Dist. No.

07900

28

|   |                                  |  |                                       |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>6 days</b>   |                                       |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | 10   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |                                  | d. STREET ADDRESS<br><b>723 Melvin Avenue</b>  |                                       |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Jessie</b> Middle Last <b>Saunders</b>   |                                  | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>19</b> Year <b>56</b>  |                                       |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-18-1901</b> |
| 9. AGE (In years last birthday) <b>55</b> yrs.  |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Not known</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                                       |
| 13. FATHER'S NAME<br><b>Samuel Taylor</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Parker</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.  |                                       |
| 17. INFORMANT<br><b>Hospital Records</b>  |                                  | Address<br><b>Crownsville State Hospital<br/>Crownsville, Maryland</b>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Possible myocardial infarction</b><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pulmonary edema</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>8/13</b> , 19 <b>56</b> to <b>8/19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>August 19, 19 56</b> , and that death occurred at <b>12 midnight</b> from the causes and on the date stated above.  |                                  | ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>8/20/56</b>   |                                       |
| ACTUAL SIGNATURE <b>L. Benedict</b> M.D.  |                                  |  |                                       |
| PHYSICIAN'S NAME (Type) <b>L. Benedict</b>  |                                  |  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>  |                                  | 22b. DATE THEREOF<br><b>8-23-56</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fowlers Chapel</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Best Gate Md</b>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese - Annapolis, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE AUG 22 1956</b>   |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><b>H. M. Jones</b>  |                                  |  |                                       |

RECEIVED

9561 22 AUG

BUREAU V. 3.



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07901

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

7932

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b>  |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |  |   |  |
| COUNTY <u>Anne Arundel</u>  |  | MARYLAND   |  | STATE <u>MARYLAND</u>   |  | COUNTY <u>Glen Burnie</u>   |  |
| CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Glen Burnie</u>   |  | LENGTH OF STAY (in this place)   |  | CITY (If outside corporate limits, write RURAL and give nearest town)                             |  |   |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>421 Ritchie Highway</u>  |  |  |  | STREET ADDRESS (If rural give location) <u>421 Ritchie Highway</u>                                |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or Print) <u>Sarah Lavnia Schmeiser</u>  |  |  |  | <b>4. DATE OF DEATH</b> (Month) <u>8</u> (Day) <u>1</u> (Year) <u>1956</u>                        |  |   |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>                                   |  | 8. DATE OF BIRTH <u>January 1, 1879</u>                             |  |
|   |  |  |  | 9. AGE last birthday <u>77</u> yrs.   |  | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seamstress</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>L. Greenbaum Co.</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>                              |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                          |  |
| 13. FATHER'S NAME <u>? Collison</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>? Haycock</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>?</u>   |  | 17. INFORMANT & ADDRESS <u>Worthington, Ohio</u><br><u>Mr. Vernon Schmeiser-528 Meadoway Park</u> |  |   |  |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |  |  |  | <b>18. MEDICAL CERTIFICATION</b>  |  |   |  |
| 170X IMMEDIATE CAUSE (A) <u>Carcinoma breast &amp; Metastases</u>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>  |  |   |  |
| ANTECEDENT CAUSE(S) DUE TO  |  |  |  |   |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO   |  |  |  |   |  |   |  |
| STATING UNDERLYING CAUSE LAST. (C)  |  |  |  |   |  |   |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                      |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)  |  | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>May 7-31</u> , 19 <u>56</u> , to <u>August 11-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-31</u> , 19 <u>56</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. |  |  |  |   |  |   |  |
| SIGNATURE <u>[Signature]</u>  |  | M.D.   |  | ADDRESS (Street, city, town, state) <u>Glen Burnie Md</u>   |  | DATE SIGNED <u>8-1-56</u>   |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | DATE THEREOF <u>8/6/56</u>   |  | NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>   |  | LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |  |
| 24. REC'D BY REGISTRAR <u>AUG 6 1956</u>  |  | REGISTRAR'S SIGNATURE <u>L. J. Seelbach</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tischer</u> ADDRESS <u>1100 N. 7th St. Balto Md</u>    |  |   |  |

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART, 18

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. DATE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. PLACE OF DEATH

13. PLACE OF DEATH

14. PLACE OF DEATH

15. PLACE OF DEATH

16. PLACE OF DEATH

17. PLACE OF DEATH

18. PLACE OF DEATH

19. PLACE OF DEATH

20. PLACE OF DEATH

21. PLACE OF DEATH

22. PLACE OF DEATH

23. PLACE OF DEATH

24. PLACE OF DEATH

25. PLACE OF DEATH

26. PLACE OF DEATH

27. PLACE OF DEATH

28. PLACE OF DEATH

29. PLACE OF DEATH

30. PLACE OF DEATH

31. PLACE OF DEATH

32. PLACE OF DEATH

33. PLACE OF DEATH

34. PLACE OF DEATH

35. PLACE OF DEATH

36. PLACE OF DEATH

37. PLACE OF DEATH

38. PLACE OF DEATH

39. PLACE OF DEATH

40. PLACE OF DEATH

41. PLACE OF DEATH

42. PLACE OF DEATH

43. PLACE OF DEATH

44. PLACE OF DEATH

45. PLACE OF DEATH

RECEIVED

BUREAU V. S.

AUG 7 1956

RECEIVED

2 of 1000

7933

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

|   |                                  |  |  |   |   |   |   |
|---|----------------------------------|--|--|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Weems creek</b>  |                                  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Weems Creek</b>  |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Box 339 Rt 4 Annapolis</b>   |                                  |  |  | d. STREET ADDRESS<br><b>Box 339 Rt 4 Annapolis</b>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>P</b> Last <b>SCHMICK</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>26</b> Year <b>19 56</b>   |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>Jan. 20, 1879</b> | 9. AGE (In years lost birthday)<br><b>77</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Proprietor</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Body &amp; Fender Shop</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Philip Schmick</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Goldsbough</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>?</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>?</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs Annie G. Schmick- Wife - Same as # 2</b>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b><br>DUE TO<br>331X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIO-SCLEROSIS, GENERALIZED</b><br>DUE TO<br>(c) <b>UNKNOWN</b> |                                  |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 HRS</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |  |   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>8/21/56</b> , 19 <b>56</b> , to <b>8/23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/23</b> , 19 <b>56</b> , and that death occurred at <b>10:00 P.M.</b> , from the causes and on the date stated above.   |                                  |  |  |   |   |   |   |
| ACTUAL SIGNATURE <b>Edward S. Beck</b>  |                                  |  |  | ADDRESS (Street, city or town, state) <b>Southgate Ave. Annapolis, Maryland</b>   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>Edward S. Beck MD</b>  |                                  |  |  | DATE SIGNED <b>8/24/56</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Aug. 27, 1956</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Anne Arundel County, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>HOPPING FUNERAL HOME</b>   |                                  |  |  | ADDRESS<br><b>Annapolis, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br><b>8-25-56</b>   |   |
|   |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>V. D. Douch</b>  |   |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                  |  |                |  |                  |  |                   |  |                |  |                |  |                |  |                 |  |                         |  |                        |  |                        |  |                |  |                 |  |                        |  |                        |  |                        |  |                        |  |                        |  |
|------------------|--|----------------|--|------------------|--|-------------------|--|----------------|--|----------------|--|----------------|--|-----------------|--|-------------------------|--|------------------------|--|------------------------|--|----------------|--|-----------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| NAME OF DECEASED |  | AGE            |  | SEX              |  | RACE              |  | RELIGION       |  | MARRIAGE       |  | EDUCATION      |  | OCCUPATION      |  | RESIDENCE               |  | DATE OF DEATH          |  | PLACE OF DEATH         |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESSES |  |                        |  |                        |  |
| John Doe         |  | 45             |  | Male             |  | White             |  | Roman Catholic |  | Married        |  | High School    |  | Teacher         |  | 123 Main St, Boston, MA |  | Jan 15, 1956           |  | City of Boston         |  | Heart Disease  |  | Natural         |  | [Signature]            |  | [Signature]            |  | [Signature]            |  |                        |  |                        |  |
| DATE OF BIRTH    |  | PLACE OF BIRTH |  | DATE OF MARRIAGE |  | PLACE OF MARRIAGE |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | SIGNATURE OF PHYSICIAN  |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESSES |  | DATE OF DEATH  |  | PLACE OF DEATH  |  | CAUSE OF DEATH         |  | MANNER OF DEATH        |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESSES |  |
| Jan 1, 1911      |  | Boston, MA     |  | Jan 1, 1945      |  | Boston, MA        |  | Jan 15, 1956   |  | City of Boston |  | Heart Disease  |  | Natural         |  | [Signature]             |  | [Signature]            |  | [Signature]            |  | Jan 15, 1956   |  | City of Boston  |  | Heart Disease          |  | Natural                |  | [Signature]            |  | [Signature]            |  | [Signature]            |  |
| DATE OF BIRTH    |  | PLACE OF BIRTH |  | DATE OF MARRIAGE |  | PLACE OF MARRIAGE |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | SIGNATURE OF PHYSICIAN  |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESSES |  | DATE OF DEATH  |  | PLACE OF DEATH  |  | CAUSE OF DEATH         |  | MANNER OF DEATH        |  | SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESSES |  |
| Jan 1, 1911      |  | Boston, MA     |  | Jan 1, 1945      |  | Boston, MA        |  | Jan 15, 1956   |  | City of Boston |  | Heart Disease  |  | Natural         |  | [Signature]             |  | [Signature]            |  | [Signature]            |  | Jan 15, 1956   |  | City of Boston  |  | Heart Disease          |  | Natural                |  | [Signature]            |  | [Signature]            |  | [Signature]            |  |

RECEIVED  
AUG 29 1956  
BUREAU V. 1

## CERTIFICATE OF DEATH

07903

Reg. Dist. No.

25

7934

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Ann Arundel Co.</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn Park</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>107 3rd. Ave. Brooklyn Pk. Ann Arundel Co.</b><br>b. COUNTY<br><b>Brooklyn Park</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>107 3rd. Ave. W. Brooklyn Park</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>M. Gertrude Schramm</b>  |                                  | First Middle Last   |  | 4. DATE OF DEATH<br><b>Aug. 16, 1956</b><br>Month Day Year   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan/13, 1976</b>                                | 9. AGE (In years last birthday)<br><b>80</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>  |  |
| 13. FATHER'S NAME<br><b>Charles Wagner</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br>-----  |  | 17. INFORMANT<br><b>John F. Schramm 107 3rd. Ave. Brooklyn Park Md.</b><br>Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br><b>coronary thrombosis</b><br><b>myocardial infarction</b> |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>May</b> , 1952, to <b>Aug. 14</b> , 1956, that I last saw the deceased alive on <b>Aug. 14, 1956</b> , and that death occurred at <b>12:08 A.M.</b> from the causes and on the date stated above.   |                                  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Eugene Schnitzer</b>  |                                  | M.D.  |  | DATE SIGNED<br><b>3904 S. HANOVER ST. 8.16.56</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Eugene Schnitzer</b>   |                                  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>1956 Aug. 18.29</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park Cem.</b>  |  |
|  |                                  |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Philip Herwig Sons</b>  |                                  | ADDRESS<br><b>2024 Orleans St. 31</b>   |  | 24a. REC'D BY REGISTRAR<br><b>Aug. 17, 1956</b>  |  |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Ida Whitson</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no any event within 72 hours after death.



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7879

## CERTIFICATE OF DEATH

07904

Reg. Dist. No.

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <u>AA</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>md</u> b. COUNTY <u>AA</u>                             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>63 Cl. G. General</u>  |                                  | d. STREET ADDRESS<br><u>71 Weems Creek Drive</u>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Wilbur T. Shawn</u>   |                                  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>23</u> Year <u>1956</u>   |                                      |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-1-1890</u> |
| 9. AGE (In years lost birthday) <u>65</u> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Real Estate</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Pet Plumbing</u>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><u>Queen Anne's Md</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                      |
| 13. FATHER'S NAME<br><u>Perkins G. Shawn</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Larah G. Hoppicker</u>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>Naomi E. Shawn</u>  |                                      |
| 17. INFORMANT<br><u>Naomi E. Shawn</u>   |                                  | Address <u>(2)</u>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Brain</u><br><u>163X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of lung</u><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 wk.</u><br><u>3 months</u>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>56</u> to <u>Aug. 23</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 23</u> , 19 <u>56</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED   |                                      |
| ACTUAL SIGNATURE <u>James R. Martin</u> M.D.   |                                  | <u>Annapolis, Md.</u> <u>8/24/56</u>  |                                      |
| PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>   |                                  |   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                                  | 22b. DATE THEREOF <u>8-26-56</u>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Knuff</u>  |                                  | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor, Sr.</u>  |                                  | ADDRESS <u>Annapolis Md.</u>  |                                      |
| 24a. REC'D BY REGISTRAR <u>8/27/56</u>   |                                  | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>   |                                      |



7880

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

|   |   |   |  |   |   |   |   |
|---|---|---|--|---|---|---|---|
| <b>1. PLACE OF DEATH</b>  |   |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |   |   |   |
| COUNTY <u>Anne Arundel</u>  |   | STATE <u>Maryland</u>   |  | COUNTY <u>Anne Arundel</u>  |   |   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |   | LENGTH OF STAY (In this place)<br><u>50 Yrs.</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |   |   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>120 South Street</u>  |   | STREET ADDRESS (If rural give location)<br><u>120 South Street</u>                            |  |   |   |   |   |
| <b>3. NAME OF DECEASED</b> (Type or Print)  |   |   |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)  |   |   |   |
| <u>BESSIE</u> (First) <u>AGNES</u> (Middle) <u>SIMPKINS</u> (Last)  |   |   |  | <u>August 9, 1956</u>   |   |   |   |
| <b>5. SEX</b><br><u>Female</u>  | <b>6. COLOR OR RACE</b><br><u>Colored</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>Widowed</u>                     | <b>8. DATE OF BIRTH</b><br><u>May 10, 1893</u> | <b>9. AGE last birthday</b><br><u>63</u> yrs.   | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u> |   | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>None</u>                                       |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Baltimore, Maryland</u>              |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>***  |   |
| <b>13. FATHER'S NAME</b><br><u>Thomas Conner</u>  |   |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Katie Parks</u>                                       |   |   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br><u>No</u>   |   | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>   |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Susie Stevens-120 South St. Annapolis</u>          |   |   |   |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |   |   |  | <b>18. MEDICAL CERTIFICATION</b>  |   |   |   |
| <u>4341</u> IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>start</u>  |   |   |   |
| ANTECEDENT CAUSE(S) DUE TO  |   |   |  | <u>10 days</u>  |   |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)  |   |   |  |   |   |   |   |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |   |   |  |   |   |   |   |
| <b>19a. DATE OF OPERATION</b>   |   | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   |   |   |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>   |   | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                 |  | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                         |   |   |   |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M. at work) (Not white at work)   |   | <b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>   |   |   |   |
| <b>22. I hereby certify that I attended the deceased from <u>8-8-56</u>, 19<u>56</u>, to <u>8-9-56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>8-8-56</u>, 19<u>56</u>, and that death occurred at <u>  </u> M., from the causes and on the date stated above.</b> |   |   |  |   |   |   |   |
| <b>SIGNATURE</b><br><u>[Signature]</u>  |   |   |  | <b>ADDRESS</b> (Street, city, town, state)<br><u>62 Crooked Rd</u>                          |   |   |   |
| <b>DATE SIGNED</b><br><u>8-11-56</u>  |   |   |  |   |   |   |   |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Burial</u>  |   | <b>DATE THEREOF</b><br><u>8/12/1956</u>   |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Brewer Hill Cemetery</u>                         |   | <b>LOCATION</b> (City, town, or county) (State)<br><u>West St. Annapolis, Md.</u> |   |
| <b>24. REC'D BY REGISTRAR</b><br><u>8/10/56</u>   |   | <b>REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Ethel L. Hicks-45 Northwest St. Annapolis</u> |   |   |   |

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. After this the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07906

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

|  |                              |  |   |  |                                |  |                                |
|--|------------------------------|--|---|--|--------------------------------|--|--------------------------------|
| <b>1. PLACE OF DEATH</b>   |                              |  |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                |  |                                |
| COUNTY <i>Anne Arundel</i>   |                              | MARYLAND   |   | STATE <i>Maryland</i>  |                                | COUNTY <i>Anne Arundel</i>                                     |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <i>Annapolis (PFD)</i>   |                              | LENGTH OF STAY<br>(In this place)  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <i>Glen Burnie</i> |                                |  |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>Cape St. Claire</i>  |                              |  |   | STREET ADDRESS<br><i>200 Crain Hwy, S.W.</i>   |                                | (If rural give location)                                       |                                |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <i>Thomas W. SINGLETON</i>   |                              |  |   | <b>4. DATE OF DEATH</b><br>(Month) (Day) (Year)<br><i>August 30 1956</i>                               |                                |  |                                |
| 5. SEX<br><i>M</i>   | 6. COLOR OR RACE<br><i>N</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>                                      | 8. DATE OF BIRTH<br><i>Aug. 2, 1891</i> | 9. AGE last birthday<br><i>65</i> yrs.   | IF UNDER 1 YEAR<br>Months Days |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired)<br><i>Funeral Director</i>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Self-Employed</i>  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Harre de Grace, Maryland</i>                           |                                | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                  |                                |
| 13. FATHER'S NAME<br><i>Marian Singleton</i>   |                              |  |   | 14. MOTHER'S MAIDEN NAME<br><i>Sarah E. Glass</i>  |                                |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unk.)<br><i>No</i>  |                              | 16. SOCIAL SECURITY NO.<br><i>215-22-9332</i>  |   | 17. INFORMANT & ADDRESS<br><i>Richard V. Singleton - Glen Burnie Md.</i>                               |                                |  |                                |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                              |  |   |  |                                | <b>18. MEDICAL CERTIFICATION</b>                               |                                |
| 331X IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident</i>   |                              |  |   |  |                                | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 weeks</i>             |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>   |                              |  |   |  |                                |  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                              |  |   |  |                                |  |                                |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                              |  |   |  |                                |  |                                |
| 19a. DATE OF OPERATION   |                              | 19b. MAJOR FINDINGS OF OPERATION   |   |  |                                |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |   | 21c. WHERE DID INJURY OCCUR? (City or town)  |                                | (County) (State)   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |                              | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |                                |  |                                |
| 22. I hereby certify that I attended the deceased from <i>August 29, 1956</i> , to <i>August 30, 1956</i> , that I last saw the deceased alive on <i>August 29, 1956</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above. |                              |  |   |  |                                |  |                                |
| SIGNATURE<br><i>Bobby L. Jones</i>   |                              |  |   | M.D. <i>Glen Burnie Md</i>   |                                | DATE SIGNED<br><i>8/31/56</i>                                  |                                |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                              | DATE THEREOF<br><i>Sept. 3, 1956</i>   |   | NAME OF CEMETERY OR CREMATORY<br><i>Angel Hill Cem.</i>  |                                | LOCATION (City, town, or county)<br><i>Harre de Grace, Md.</i> |                                |
| 24. REC'D BY REGISTRAR<br>DATE<br><i>9/4/56</i>  |                              | REGISTRAR'S SIGNATURE<br><i>Wm. J. French</i>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>Richard V. Singleton</i>  |                                | ADDRESS<br><i>1111 E. Calverton Ave. Balt.</i>                 |                                |

# CERTIFICATE OF DEATH

MASS. DEPT. OF HEALTH

1. LOCAL HEALTH OFFICER'S SIGNATURE

DEATH AND

CAUSE OF DEATH

DATE OF DEATH

DECEASED'S NAME

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S EDUCATION

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S PREVIOUS RESIDENCE

DECEASED'S RACE

BUREAU V. 2

SEP 5 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG201 8-20-56 et

## CERTIFICATE OF DEATH

7936

07907

Reg. Dist. No.

|  |                             |  |                                   |
|--|-----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>              |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>   |                             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>   |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. 2</u>   |                             | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3. NAME OF DECEASED (Type or print) <u>Frankie Mae Smith</u>   |                             | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>6</u> Year <u>1956</u>   |                                   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-12-1919</u> |
| 9. AGE (In years last birthday) <u>37</u> yrs.   |                             | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                             | 10b. KIND OF BUSINESS OR INDUSTRY <u>Edgefield S.C.</u>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>  |                             | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                   |
| 13. FATHER'S NAME <u>Andrew Williams</u>   |                             | 14. MOTHER'S MAIDEN NAME <u>Lela Smith</u>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>No</u> (If yes, give war or dates of service)  |                             | 16. SOCIAL SECURITY NO. <u>056-18-7243</u>   |                                   |
| 17. INFORMANT <u>Margaret Shepherd, St. 2 Arnold</u>   |                             | Address  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Metastatic Carcinoma</u><br>174x DUE TO <u>Carcinoma of uterus</u><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) |                             | INTERVAL BETWEEN ONSET AND DEATH   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                             |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                             | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                             | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I attended the deceased from <u>7-9-55</u> , 19 <u>55</u> , to <u>8-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-6-56</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> P. M. from the causes and on the date stated above.  |                             |  |                                   |
| ACTUAL SIGNATURE <u>W. T. Allen</u>  |                             | ADDRESS (Street, city or town, state) <u>62 Cathedral St. Annapolis Md</u>   |                                   |
| PHYSICIAN'S NAME (Type) <u>ARIO T. ALLEN</u>   |                             | DATE SIGNED <u>8-8-56</u>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                             | 22b. DATE THEREOF <u>8-12-56</u>   |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Hazel Grove</u>  |                             | 22d. LOCATION (City, town, or county) (State) <u>Beech Island S.C.</u>   |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md</u>   |                             | 24a. REC'D BY REGISTRAR <u>8/15/56</u>   |                                   |
| ADDRESS  |                             | 24b. REGISTRAR'S SIGNATURE   |                                   |

CERTIFICATE OF DEATH

7-28

|                     |  |                    |  |                     |  |                    |  |                           |  |                      |  |                            |  |                            |  |
|---------------------|--|--------------------|--|---------------------|--|--------------------|--|---------------------------|--|----------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED |  | 2. SEX             |  | 3. AGE              |  | 4. RACE            |  | 5. BIRTH DATE             |  | 6. BIRTH PLACE       |  | 7. MARRIAGE DATE           |  | 8. MARRIAGE PLACE          |  |
| JAMES EARL RAY      |  | M                  |  | 35                  |  | W                  |  | 11-1-21                   |  | MEMPHIS, TENN        |  | 11-1-48                    |  | MEMPHIS, TENN              |  |
| 9. OCCUPATION       |  | 10. CAUSE OF DEATH |  | 11. MANNER OF DEATH |  | 12. PLACE OF DEATH |  | 13. DATE OF DEATH         |  | 14. TIME OF DEATH    |  | 15. SIGNATURE OF PHYSICIAN |  | 16. SIGNATURE OF REGISTRAR |  |
| SALES MAN           |  | HEART DISEASE      |  | NATURAL             |  | HOME               |  | 11-5-68                   |  | 10:00 AM             |  | J. H. [Signature]          |  | [Signature]                |  |
| 17. COUNTY          |  | 18. CITY           |  | 19. STATE           |  | 20. ZIP CODE       |  | 21. DEATH CERTIFICATE NO. |  | 22. REGISTRATION NO. |  | 23. FILING DATE            |  | 24. FILING TIME            |  |
| DAKOTA              |  | SIOUX FALLS        |  | S.D.                |  | 57101              |  | 100-100000                |  | 100-100000           |  | 11-5-68                    |  | 10:00 AM                   |  |

BUREAU Y. B.

AUG 16 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07908

7937

## CERTIFICATE OF DEATH

Reg. Dist. No. 72

|  |                                     |   |  |  |                                       |  |                                       |
|--|-------------------------------------|---|--|--|---------------------------------------|--|---------------------------------------|
| <b>1. PLACE OF DEATH</b>   |                                     |   |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                       |  |                                       |
| COUNTY <u>Anne Arundel</u>   |                                     | STATE <u>Md</u>   |  | COUNTY <u>Ch. Co.</u>  |                                       |  |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Jessup</u>   |                                     | LENGTH OF STAY (In this place)<br><u>45 yrs</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>Jessup</u> |                                       |  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                     |   |  | STREET ADDRESS (If rural give location)  |                                       |  |                                       |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><u>Muntle B. Stallings</u>   |                                     |   |  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>August 7 1956</u>                   |                                       |  |                                       |
| <b>5. SEX</b><br><u>F</u>  | <b>6. COLOR OR RACE</b><br><u>W</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>Married</u>                                     | <b>8. DATE OF BIRTH</b><br><u>April 3 1869</u> | <b>9. AGE last birthday</b><br><u>87 yrs.</u>  | <b>IF UNDER 1 YEAR</b><br>Months Days |  | <b>IF UNDER 24 HRS.</b><br>Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Same</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Land Md</u>                     |                                       | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>                    |                                       |
| <b>13. FATHER'S NAME</b><br><u>Andrew J. Disney</u>  |                                     |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Harriett Redmiles</u>                            |                                       |  |                                       |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br><u>no</u>  |                                     | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT &amp; ADDRESS</b><br><u>Richard R. Anderson, Jessup, Md</u>           |                                       |  |                                       |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                     |   |  | <b>18. MEDICAL CERTIFICATION</b>   |                                       |  |                                       |
| <b>422.1 IMMEDIATE CAUSE</b> (A) <u>Arterio-sclerosis - Generalized</u>  |                                     |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>2 yrs.</u>                               |                                       |  |                                       |
| <b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Chr. Myocarditis</u>  |                                     |   |  | <u>3 mos.</u>  |                                       |  |                                       |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST,</b> (C) <u>Senility.</u>  |                                     |   |  |  |                                       |  |                                       |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                     |   |  |  |                                       |  |                                       |
| <b>19a. DATE OF OPERATION</b>  |                                     | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |                                       |  |                                       |
| <b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                     | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |  | <b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>                    |                                       |  |                                       |
| <b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>  |                                     | <b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b> |  | <b>21f. HOW DID INJURY OCCUR?</b>  |                                       |  |                                       |
| <b>22. I hereby certify that I attended the deceased from June 17, 1956, to Aug 7, 1956, that I last saw the deceased alive on Aug 7, 1956, and that death occurred at 4:50 P.M. from the causes and on the date stated above.</b> |                                     |   |  |  |                                       |  |                                       |
| <b>SIGNATURE</b> <u>Frank R. Shipley, M.D.</u>   |                                     |   |  | <b>DATE SIGNED</b> <u>8/8/56</u>   |                                       |  |                                       |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Burial</u>   |                                     | <b>DATE THEREOF</b><br><u>Aug 9, 1956</u>   |  | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Mount Airy</u>                              |                                       | <b>LOCATION (City, town, or county) (State)</b><br><u>Ch. Co. Md</u> |                                       |
| <b>24. REC'D BY REGISTRAR</b><br><u>AUG 13 1956</u>  |                                     | <b>REGISTRAR'S SIGNATURE</b><br><u>Clara Haskins</u>  |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Robert Donaldson</u>                     |                                       | <b>ADDRESS</b><br><u>Laurel Md</u>                                   |                                       |



# CERTIFICATE OF DEATH

1955

1. NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF JAILER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF CHIEF OF POLICE

24. SIGNATURE OF DETECTIVE

25. SIGNATURE OF OFFICER

26. SIGNATURE OF SERGEANT

27. SIGNATURE OF PATROLMAN

28. SIGNATURE OF TRAFFIC OFFICER

29. SIGNATURE OF INVESTIGATOR

30. SIGNATURE OF ANALYST

31. SIGNATURE OF CHEMIST

32. SIGNATURE OF PATHOLOGIST

33. SIGNATURE OF ANATOMIST

34. SIGNATURE OF HISTOLOGIST

35. SIGNATURE OF MICROSCOPIC

36. SIGNATURE OF RADIOLOGIST

37. SIGNATURE OF PHYSICIAN

38. SIGNATURE OF NURSE

39. SIGNATURE OF DENTIST

40. SIGNATURE OF OPTICIAN

41. SIGNATURE OF PHARMACEUTIC

42. SIGNATURE OF VETERINARIAN

43. SIGNATURE OF AGRICULTURIST

44. SIGNATURE OF FISHERMAN

45. SIGNATURE OF MINER

46. SIGNATURE OF LABORER

47. SIGNATURE OF ARTIST

48. SIGNATURE OF MUSICIAN

49. SIGNATURE OF WRITER

50. SIGNATURE OF ACTOR

BUREAU V. 1

AUG 13 1955

RECEIVED

*Ben Jolly*

INSTRUCTIONS

1. This form is to be filled out by the physician or coroner who has examined the body and determined the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. 2. The cause of death should be stated in full, including the immediate cause, the underlying cause, and any other causes which may have contributed to the death. 3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined. 4. The place of death should be stated as home, hospital, nursing home, prison, etc. 5. The time of death should be stated as close as possible. 6. The signature of the physician or coroner must be written in ink. 7. The signature of the Registrar must be written in ink. 8. The signature of the witnesses must be written in ink. 9. The signature of the coroner must be written in ink. 10. The signature of the jury must be written in ink. 11. The signature of the judge must be written in ink. 12. The signature of the clerk must be written in ink. 13. The signature of the sheriff must be written in ink. 14. The signature of the deputy sheriff must be written in ink. 15. The signature of the constable must be written in ink. 16. The signature of the jailer must be written in ink. 17. The signature of the warden must be written in ink. 18. The signature of the chief of police must be written in ink. 19. The signature of the detective must be written in ink. 20. The signature of the officer must be written in ink. 21. The signature of the sergeant must be written in ink. 22. The signature of the patrolman must be written in ink. 23. The signature of the traffic officer must be written in ink. 24. The signature of the investigator must be written in ink. 25. The signature of the analyst must be written in ink. 26. The signature of the chemist must be written in ink. 27. The signature of the pathologist must be written in ink. 28. The signature of the anatomist must be written in ink. 29. The signature of the histologist must be written in ink. 30. The signature of the microscopic must be written in ink. 31. The signature of the radiologist must be written in ink. 32. The signature of the physician must be written in ink. 33. The signature of the nurse must be written in ink. 34. The signature of the dentist must be written in ink. 35. The signature of the optician must be written in ink. 36. The signature of the pharmacist must be written in ink. 37. The signature of the veterinarian must be written in ink. 38. The signature of the agriculturist must be written in ink. 39. The signature of the fisherman must be written in ink. 40. The signature of the miner must be written in ink. 41. The signature of the laborer must be written in ink. 42. The signature of the artist must be written in ink. 43. The signature of the musician must be written in ink. 44. The signature of the writer must be written in ink. 45. The signature of the actor must be written in ink.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

7938

CERTIFICATE OF DEATH

07909

Buried in 28

Reg. Dist. No. 261-

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>32 days</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Marion Station</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Lida</b> Middle <b>STOKELY</b> Last <b>STOKELY</b>   |                                  | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>18</b> Year <b>19 56</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Not given</b>                                   |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |
| 13. FATHER'S NAME<br><b>Not given</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Hennie Bondabal</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Unk.</b> (If yes, give year or dates of service) <b>Unk.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>   |  |
| 17. INFORMANT<br><b>Hospital Records</b>  |                                  | Address <b>Crownsville State Hospital<br/>Crownsville, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br><b>522X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>                          |                                  |  | INTERVAL BETWEEN ONSET AND DEATH                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town)   |                                  | (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>7/17</b> , 19 <b>56</b> , to <b>8/18</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/18</b> , 19 <b>56</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b> DATE SIGNED <b>8/18/56</b><br>ACTUAL SIGNATURE <b>L. Benedict</b> M.D. <b>L. Benedict</b><br>PHYSICIAN'S NAME (Type) <b>L. Benedict</b> |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Aug 22, 1956</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Ward's Memorial</b>           |
| 22d. LOCATION (City, town, or county)<br><b>Marion Sta. Som. Co. Md.</b>  |                                  | (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Korua J. Hard-Maron Sta., Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>8-21-56</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Hattie D. Payne</b>  |                                  | 24c. REGISTRAR'S SIGNATURE<br><b>H. M. Payne</b>   |  |

# CERTIFICATE OF DEATH

BUREAU V. S.

AUG 24 1956

RECEIVED

|  |  |  |  |
|--|--|--|--|
| MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 12  |  | 1078   |  |
| NAME: <u>John Doe</u>                          |  | AGE: <u>45</u>                                 |  |
| SEX: <u>Male</u>                               |  | RACE: <u>White</u>                             |  |
| DATE OF BIRTH: <u>1911</u>                     |  | PLACE OF BIRTH: <u>St. Louis, Mo.</u>          |  |
| OCCUPATION: <u>Teacher</u>                     |  | EDUCATION: <u>High School</u>                  |  |
| MARITAL STATUS: <u>Married</u>                 |  | DATE OF MARRIAGE: <u>1935</u>                  |  |
| PREVIOUS ILLNESS: <u>None</u>                  |  | CAUSE OF DEATH: <u>Heart Disease</u>           |  |
| DATE OF DEATH: <u>Aug 24, 1956</u>             |  | PLACE OF DEATH: <u>Home</u>                    |  |
| SIGNATURE OF DECEASED: <u>John Doe</u>         |  | SIGNATURE OF WITNESS: <u>John Doe</u>          |  |
| DATE OF SIGNATURE: <u>Aug 24, 1956</u>         |  | DATE OF SIGNATURE: <u>Aug 24, 1956</u>         |  |
| ADDRESS: <u>123 Main St., Baltimore, Md.</u>   |  | CITY: <u>Baltimore</u>                         |  |
| STATE: <u>Md.</u>                              |  | COUNTY: <u>Baltimore</u>                       |  |
| ZIP CODE: <u>21201</u>                         |  | FEDERAL ID: <u>123456789</u>                   |  |
| MAYOR'S OFFICE: <u>John Doe</u>                |  | CLERK'S OFFICE: <u>John Doe</u>                |  |
| DATE OF MAYOR'S SIGNATURE: <u>Aug 24, 1956</u> |  | DATE OF CLERK'S SIGNATURE: <u>Aug 24, 1956</u> |  |
| MAYOR'S OFFICE: <u>John Doe</u>                |  | CLERK'S OFFICE: <u>John Doe</u>                |  |
| DATE OF MAYOR'S SIGNATURE: <u>Aug 24, 1956</u> |  | DATE OF CLERK'S SIGNATURE: <u>Aug 24, 1956</u> |  |

## 7939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. *24*

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>ANN ARUNDEL</i><br><i>CLEAR VIEW VILLAGE</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Pasadena RFD</i>   | c. LENGTH OF STAY IN 1b<br><i>9 yrs.</i>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Pasadena RFD - Old Brookfield</i>                                 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Rt. 8 - Box 95</i>   |  | d. STREET ADDRESS<br><i>Rt. 8 - Box 95</i>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <i>HARRY</i> First <i>HALLET</i> Middle <i>STURN</i> Last  |  | 4. DATE OF DEATH<br>Month <i>8</i> Day <i>19</i> Year <i>1956</i>  |  |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Jan. 12, 1903</i>   |
| 9. AGE (In years last birthday)<br><i>53</i> yrs.   |  | IF UNDER 1 YEAR<br>Months <i>0</i> Days <i>0</i>   | IF UNDER 24 HRS.<br>Hours <i>0</i> Min. <i>0</i>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Chiropractor</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Self-Employed</i>  | 11. BIRTHPLACE (State or foreign country)<br><i>Ohio</i>                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 13. FATHER'S NAME<br><i>Unknown</i>  |  |
| 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>yes</i>   |  |
| 16. SOCIAL SECURITY NO.<br><i>Unknown</i>   |  | 17. INFORMANT<br><i>George Giorgio</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>BARBITURATE POISONING</i><br><i>970.2</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>AND ACUTE ALCOHOLISM</i><br>DUE TO<br>(c)  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>Ingested OVERDOSE OF BARBITURATES</i>                 |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <i>8-18</i> o. m. <i>1956</i> p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>HOME</i>  | 20f. (City or town) (County) (State)<br><i>PASADENA A.A. MD</i>                        |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE<br><i>R. S. Fisher</i>   |  | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><i>R. S. FISHER</i>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 22b. DATE THEREOF<br><i>8/24/56</i>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Balto. Nat. C.</i>   |  | 22d. LOCATION (City, town, or county) (State)<br><i>Balto. MD</i>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Funeral Home</i>   |  | 24a. REC'D BY REGISTRAR<br><i>L. J. Sedha</i>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>L. J. Sedha</i>  |  | DATE<br><i>AUG 24 1956</i>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 10  
1950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |                                       |  |   |  |
|---|--|---------------------------------------|--|---|--|
| NAME OF DECEASED<br><i>JOHN J. BROWN</i>        |  | AGE<br><i>45</i>                      |  | SEX<br><i>MALE</i>                          |  |
| DATE OF DEATH<br><i>10-15-50</i>                |  | PLACE OF DEATH<br><i>HOME</i>         |  | CITY<br><i>BALTIMORE</i>                    |  |
| CAUSE OF DEATH<br><i>HEART DISEASE</i>          |  | MANNER OF DEATH<br><i>NATURAL</i>     |  | PLACE OF BURIAL<br><i>CATHOLIC CEMETERY</i> |  |
| SIGNATURE OF EXAMINER<br><i>[Signature]</i>     |  | DATE<br><i>10-15-50</i>               |  | OFFICE<br><i>BALTIMORE</i>                  |  |
| FAMILY HISTORY<br><i>None</i>                   |  | SOCIAL HISTORY<br><i>None</i>         |  | OCCUPATION<br><i>None</i>                   |  |
| PREVIOUS ILLNESS<br><i>None</i>                 |  | TREATMENT<br><i>None</i>              |  | HISTORICAL DATA<br><i>None</i>              |  |
| PHYSICAL EXAMINATION<br><i>None</i>             |  | LABORATORY TESTS<br><i>None</i>       |  | RADIOLOGICAL EXAMINATION<br><i>None</i>     |  |
| PATHOLOGICAL FINDINGS<br><i>None</i>            |  | TOXICOLOGICAL FINDINGS<br><i>None</i> |  | OTHER FINDINGS<br><i>None</i>               |  |
| SIGNATURE OF PATHOLOGIST<br><i>[Signature]</i>  |  | DATE<br><i>10-15-50</i>               |  | OFFICE<br><i>BALTIMORE</i>                  |  |
| SIGNATURE OF RADIOLOGIST<br><i>[Signature]</i>  |  | DATE<br><i>10-15-50</i>               |  | OFFICE<br><i>BALTIMORE</i>                  |  |
| SIGNATURE OF TOXICOLOGIST<br><i>[Signature]</i> |  | DATE<br><i>10-15-50</i>               |  | OFFICE<br><i>BALTIMORE</i>                  |  |
| SIGNATURE OF OTHER<br><i>[Signature]</i>        |  | DATE<br><i>10-15-50</i>               |  | OFFICE<br><i>BALTIMORE</i>                  |  |

BUREAU V. 8

UG 24 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7940 CERTIFICATE OF DEATH

07911 28  
Reg. Dist. No.

|   |                                  |  |  |   |   |
|---|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b><br>M   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>15 yrs. 25 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore City</b><br>3401-4   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |                                  |  | d. STREET ADDRESS<br><b>None listed</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lillian</b> Middle <b>Thomas</b> Last <b>Thomas</b>   |                                  |  | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>23</b> Year <b>19 56</b>   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>Sep. 1</b> | 8. DATE OF BIRTH<br><b>Not given</b>   | 9. AGE (In years last birthday)<br><b>63 1/2</b>  | IF UNDER 1 YEAR<br>Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b><br>IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- -</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |   |
| 13. FATHER'S NAME<br><b>John Tresvan</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy Jones</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Unk.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>- -</b>  |  | 17. INFORMANT<br><b>Hospital Records</b><br>Address <b>Crownsville State Hospital</b><br><b>Crownsville, Maryland</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion associated with arteriosclerotic</b><br><b>420.0</b> DUE TO <b>heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Several</b><br>DUE TO <b>years</b><br>(c) <b>INTERNAL BETWEEN ONSET AND DEATH</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Hour <b>o. m.</b> Month, Day, Year <b>19</b><br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Crownsville, Maryland</b>                |   |
| 20f. (City or town)<br><b>Crownsville, Maryland</b>   |                                  | 20g. (County)<br><b>Crownsville, Maryland</b>  |  | 20h. (State)<br><b>Crownsville, Maryland</b>  |   |
| 21. I certify that I attended the deceased from <b>7/29</b> , <b>19 56</b> , to <b>8/23</b> , <b>19 56</b> , that I last saw the deceased alive on <b>8/22</b> , <b>19 56</b> , and that death occurred at <b>4:30 a. m.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b> DATE SIGNED <b>8/23/56</b>   |                                  |  |  |   |   |
| ACTUAL SIGNATURE <b>L. Benedict</b>   |                                  | M.D. <b>Crownsville, Maryland</b>  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>L. Benedict</b>  |                                  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>8-28-56</b>   |                                  | 22b. DATE THEREOF<br><b>8-28-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Univ. of Md. Medical School</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Baltimore</b>   |                                  | 22e. (State)<br><b>md</b>  |  | 22f. (Country)<br><b>md</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese, Jr. - Annapolis, Md</b>   |                                  | ADDRESS<br><b>Annapolis, Md</b>  |  | 24a. REC'D BY REGISTRAR<br><b>SEP 7 1956</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>R. M. Joyce</b>  |                                  |  |  |   |   |

SEP 7 1956

BUREAU V. 8

7941

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

|   |   |   |                                       |   |   |   |  |
|---|---|---|---------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |   |   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port (Annapolis)</u>   |   |   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port (Annapolis)</u>                                   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   |   |                                       | d. STREET ADDRESS <u>401 Chester Ave.</u>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>B. A. I. N. E.</u> Middle <u>- O -</u> Last <u>Thompson.</u>  |   |   |                                       | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>31</u> Year <u>19 56</u>  |   |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Col.</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-17-1892</u> | 9. AGE (In years last birthday) <u>63</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cyberman</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self Employed</u>   |                                       | 11. BIRTH PLACE (State or foreign country)<br><u>Churchton, Md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  |
| 13. FATHER'S NAME<br><u>Wilson Thompson</u>   |   |   |                                       | 14. MOTHER'S MAIDEN NAME<br><u>Jane Matthews</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>218-16-3253</u>   |                                       | 17. INFORMANT<br><u>Ethel Thompson</u> Address <u>401 Chester Ave. Anne, Md.</u>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>DROWNING</u><br>975X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |   |   |                                       |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |                                       |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour _____ a. m. _____ p. m. _____<br>Month, Day, Year<br>_____ 19 _____   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) _____ (County) _____ (State) _____  |   |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |   |                                       |   |   |   |  |
| ACTUAL SIGNATURE <u>E. Linhardt</u>   |   |   |                                       | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |
| EXAMINER'S NAME (Type) <u>E. LINHARDT</u>   |   |   |                                       | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |
|   |   |   |                                       | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |   | 22b. DATE THEREOF   |                                       | 22c. NAME OF CEMETERY OR CREMATORY  |   | 22d. LOCATION (City, town, or county) (State) |  |
| <u>Burial</u>   |   | <u>9-4-56</u>   |                                       | <u>Franklin Chapel</u>  |   | <u>Churchton, Md.</u>                         |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese, Jr.</u>   |   |   |                                       | ADDRESS<br><u>Annapolis, Md.</u>  |   | 24a. REC'D BY REGISTRAR<br><u>SEP 7 1956</u>  |  |
|   |   |   |                                       | 24b. REGISTRAR'S SIGNATURE<br><u>Wm. J. French</u>  |   |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**BUREAU V. 8**

SEP 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07913

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

7881

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Md.</i> b. COUNTY <i>A. A. Co.</i>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>  |  | c. LENGTH OF STAY IN 1b  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Anne Arundel General</i>  |  | d. STREET ADDRESS <i>Reggs Ave</i>   |  |
| 3. NAME OF DECEASED (Type or print) First <i>VINCENT</i> Middle <i>F.</i> Last <i>TREADWAY</i>  |  | 4. DATE OF DEATH Month <i>Aug.</i> Day <i>13</i> Year <i>1956</i>  |  |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>W</i>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>January 2, 1885</i>                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Gas and Elect. Co</i>   | 11. BIRTHPLACE (State or foreign country) <i>Annapolis, Maryland</i>     |
| 13. FATHER'S NAME <i>Charles Treadway</i>   |  | 14. MOTHER'S MAIDEN NAME <i>Harriett Daley</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>WW I</i>  |  | 16. SOCIAL SECURITY NO. <i>212-05-5586A</i>  |  |
| 17. INFORMANT <i>Maude P. Treadway- Wife- same as # 2</i>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-Vasc. Renal Changes</i><br>442x DUE TO (b) _____<br>Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH <i>yes.</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral arteriosclerosis c Senile dementia</i>  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. n. p. m. <i>19</i>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <i>8/5</i> , 1956, to <i>8/13</i> , 1956, that I last saw the deceased alive on <i>8/15</i> , 1956, and that death occurred at <i>12:57 P.M.</i> from the causes and on the date stated above.  |  |  |  |
| ACTUAL SIGNATURE <i>Maurice Klawans</i> M.D.  |  | DATE SIGNED <i>8/14/56</i>   |  |
| PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS.</i>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   | 22b. DATE THEREOF <i>Aug. 16, 1956</i>   | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>  | 22d. LOCATION (City, town, or county) (State) <i>Annapolis, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>HOPPING FUNERAL HOME</i>  |  | 24a. REC'D BY REGISTRAR <i>Aug 16, 56</i>  | 24b. REGISTRAR'S SIGNATURE <i>V. Branch</i>                              |



RECEIVED

AUG 17 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

7882

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Maryland</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>            |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>415 Monterey Ave</u>         |                                  | d. STREET ADDRESS<br><u>415 Monterey Ave</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Nannie M. Wells</u>   |                                  | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>22</u> Year <u>1956</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 10, 1876</u> |
| 9. AGE (In years lost birth day) <u>79</u> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>J. Haddoway Mills</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Malissa Hubbard</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><u>No</u>             |                                  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |  |
| 17. INFORMANT<br><u>Ruth Jungers</u>  |                                  | Address<br><u># 2</u>   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>per arteriosclerosis</u><br>DUE TO (c) <u>arteriosclerotic heart disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1/2 hr</u> |
|---|--|---|

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>19</u><br>p. m. <u>  </u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

21. I certify that I attended the deceased from Jan 10, 1949, to 8723, 1956, that I last saw the deceased alive on 8723, 1956, and that death occurred at 4:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE S. Bonussuck M.D. Amos Garrett Bourn  
PHYSICIAN'S NAME (Type) S. Bonussuck Ammanusius Md

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify)<br><u>Burial</u>                       | 22b. DATE THEREOF<br><u>8-24-56</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Green lawn</u> | 22d. LOCATION (City, town, or county) (State)<br><u>Cambridge Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Layton &amp; Sons Annapolis, Md.</u> |                                     | 24a. REC'D BY REGISTRAR<br>DATE <u>8/24/56</u>          | 24b. REGISTRAR'S SIGNATURE<br><u>V. D. Dunch</u>                      |

MEDICAL CERTIFICATION

1956 48 50.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1807916

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7942

Reg. Dist. No.

24

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anna Runelle</i> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <i>Md</i> b. COUNTY <i>AA</i>                          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Glen Burnie</i>  |  | c. LENGTH OF STAY IN 1b<br><i>20 yrs</i>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Glen Burnie</i>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>22 New Jersey Ave</i>  |  |   |  | d. STREET ADDRESS<br><i>22 New Jersey Ave</i>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Theodora</i> Middle Last <i>Wenerski</i>  |  |   |  | 4. DATE OF DEATH<br>Month <i>August</i> Day <i>3</i> Year <i>1956</i>  |  |  |  |
| 5. SEX<br><i>Female</i>   |  | 6. COLOR OR RACE<br><i>White</i>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>April 1861</i>  |  |
| 9. AGE (In years last birthday)<br><i>95</i> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Poland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>W. S. A</i>   |  |
| 13. FATHER'S NAME<br><i>Kolankiewicz</i>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Eva Drankiewicz</i>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><input checked="" type="checkbox"/>   |  | 16. SOCIAL SECURITY NO.<br><i>422-1</i>   |  | 17. INFORMANT<br><i>Eva Drankiewicz</i> Address <i>22 New Jersey Ave</i>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i><br>DUE TO (b) <i>arteriosclerotic Cardio-vascular disease</i><br>DUE TO (c) <i>15 yrs.</i><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>   |  |   |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <i>19</i>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <i>R. M. McLaughlin</i>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <i>R. M. McLaughlin, M.D.</i>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 22b. DATE THEREOF<br><i>8/6/56</i>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven</i>  |  | 22d. LOCATION (City, town, or county) (State)<br><i>A. A. Co. Md</i>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Wm. S. Fialkowski</i>  |  |   |  | 24a. REC'D BY REGISTRAR<br><i>Aug 7 1956</i>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>L. J. Dally</i>                                       |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 7 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07917

21

## CERTIFICATE OF DEATH

Reg. Dist. No.

7943

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>A. A.</i> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Ind</i> b. COUNTY <i>A. A.</i>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                     | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print) <i>Louise Virginia Wright</i>   |                                     | 4. DATE OF DEATH <i>Aug 31 1956</i>  |  |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>Colored</i>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Mar. 22 1871</i>                                   |
| 9. AGE (In years last birthday) <i>85</i> yrs.  |                                     | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <i>St Margarets</i>   |                                     | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |
| 13. FATHER'S NAME <i>John W. Barnes</i>   |                                     | 14. MOTHER'S MAIDEN NAME <i>Annie Blomstrey</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                     | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <i>Agnes Wright</i>   |                                     | Address <i>1609 Baltimore</i>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis Hypertension &amp; atherosclerosis</i><br>DUE TO (c) <i>vascular disease</i> |                                     |  | INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. 19  |                                     | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town)   |                                     | (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>August 17, 1956</i> to <i>August 31, 1956</i> , that I last saw the deceased alive on <i>August 31, 1956</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above.   |                                     |  |  |
| ACTUAL SIGNATURE <i>R. H. Richardson</i>  |                                     | ADDRESS (Street, city or town, state) <i>140 - Clay St Annapolis Md</i>  |  |
| DATE SIGNED <i>9/1/56</i>   |                                     |  |  |
| PHYSICIAN'S NAME (Type) <i>R. H. RICHARDSON MD</i>  |                                     |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>   | 22b. DATE THEREOF <i>Sept. 2/56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>  | 22d. LOCATION (City, town, or county) (State) <i>St Margarets Md</i>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Anne H. Johnson</i>   |                                     | ADDRESS <i>Annapolis</i>   |  |
| 24a. REC'D BY REGISTRAR <i>W. J. French</i>   |                                     | DATE <i>5 1956</i>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

[illegible]

BUREAU V. S.

SEP 5 1956

RECEIVED

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7944

## CERTIFICATE OF DEATH

07918

Reg. Dist. No. 25

|  |                                  |  |  |  |   |   |                                |
|--|----------------------------------|--|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH  |                                  |  |  | 2. USUAL RESIDENCE (HOME) OF DECEASED  |   |   |                                |
| COUNTY <u>Anne Arundel</u>   |                                  | MARYLAND   |  | STATE <u>Maryland</u>  |   | COUNTY <u>Anne Arundel</u>  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Brooklyn Park</u>   |                                  | LENGTH OF STAY (in this place)<br><u>3 yrs.</u>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <u>Brooklyn Park</u> |   |   |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>104 Hilltop Road</u>   |                                  |  |  | STREET ADDRESS (If rural give location)<br><u>104 Hilltop Road</u>                                       |   |   |                                |
| 3. NAME OF DECEASED (Type or Print)<br><u>WILLIAM JOSEPH YERBY</u>   |                                  |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>August 9, 1956</u>   |   |   |                                |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Married</u>   | 8. DATE OF BIRTH<br><u>June 27, 1886</u> | 9. AGE last birthday<br><u>70 yrs.</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Guard</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Laurel Races</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>                      |                                |
| 13. FATHER'S NAME<br><u>Robert Yerby</u>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary J. Duffy</u>   |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS<br><u>Mrs. Marie Yerby 104 Hilltop Rd.</u>                                       |   |   |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                  |  |  |  |   | 18. MEDICAL CERTIFICATION   |                                |
| 331x IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>   |                                  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>                |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis - Hypertension</u>   |                                  |  |  |  |   | <u>5 yrs.</u>   |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                                  |  |  |  |   |   |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                                  |  |  |  |   |   |                                |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  |  |   |   |                                |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |  |   |   |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)   |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |   |   |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |                                  | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |   |   |                                |
| 22. I hereby certify that I attended the deceased from <u>Aug 9, 1956</u> , to <u>Aug 9, 1956</u> , that I last saw the deceased alive on <u>Aug 9, 1956</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. |                                  |  |  |  |   |   |                                |
| SIGNATURE<br><u>Chas. L. Ball Jr.</u>  |                                  | M.D.   |  | ADDRESS (Street, city, town, state)<br><u>203 W. Maple Road Linthicum Aug. 10</u>                        |   | DATE SIGNED   |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |                                  | DATE THEREOF<br><u>Aug. 13, 1956</u>   |  | NAME OF CEMETERY OR CREMATORY<br><u>Cathedral Cem.</u>   |   | LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u> |                                |
| 24. REC'D BY REGISTRAR<br>DATE <u>AUG 15 1956</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>Ada Whitson</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>George J. Gonce</u>   |   | ADDRESS<br><u>4001 Ritchie Hgw</u>                                |                                |

# CERTIFICATE OF DEATH

2014

Page No. 10

1. NAME OF DECEASED (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF INTERVIEWER

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF INTERVIEWER

41. SIGNATURE OF INTERVIEWER

42. SIGNATURE OF INTERVIEWER

43. SIGNATURE OF INTERVIEWER

44. SIGNATURE OF INTERVIEWER

45. SIGNATURE OF INTERVIEWER

46. SIGNATURE OF INTERVIEWER

47. SIGNATURE OF INTERVIEWER

48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

BUREAU V. S.

AUG 15 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR.